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ON DETAINING 300,000 PEOPLE: THE LIBERTY PROTECTION SAFEGUARDS

DR LUCY SERIES*

ABSTRACT

The Mental Capacity (Amendment) Act 2019 will introduce a new framework—the Liberty Protection Safeguards (LPS)—for authorising arrangements giving rise to a deprivation of liberty to enable the care and treatment of people who lack capacity to consent to them in England and Wales. The LPS will replace the heavily criticised Mental Capacity Act 2005 deprivation of liberty safeguards (MCA DoLS). The new scheme must provide detention safeguards on an unprecedented scale and across a much more diverse range of settings than traditional detention frameworks linked to mental disability. Accordingly, the LPS are highly flexible, and grant detaining authorities considerable discretion in how they perform this safeguarding function. This review outlines the background to the 2019 amendments to the MCA, and contrasts the LPS with the DoLS. It argues that although the DoLS were in need of reform, the new scheme also fails to deliver adequate detention safeguards, and fails to engage with the pivotal question: what are these safeguards *for*?

Keywords: Mental Capacity (Amendment) Act 2019; Mental Capacity Act 2005; deprivation of liberty safeguards; liberty protection safeguards; article 5 European Convention on Human Rights; *P v Cheshire West and Chester Council and another*; *P and Q v Surrey County Council* [2014] UKSC 19; [2014] A.C. 896; [2014] H.R.L.R. 13

I. INTRODUCTION

The Mental Capacity (Amendment) Act 2019 was supposed to be a ‘really small, uncontroversial’ Bill,¹ one the whips could safely steer through a febrile parliamentary session engulfed by Brexit-related chaos. Its object and purpose was to replace the current administrative framework for authorising deprivation of liberty in care homes and hospitals – the Mental Capacity Act 2005 deprivation of liberty safeguards (DoLS) – which were universally agreed to be broken and in need of reform. As it happened, the whips were wrong; the Bill was widely criticised and the government was defeated three times in the Lords. However, the Bill received Royal Assent in May 2019 and is planned to commence in October 2020.²

The 2019 amendments to the Mental Capacity Act 2005 (MCA) replaced the DoLS with a successor scheme: the Liberty Protection Safeguards (LPS).³ The LPS are intended to deliver safeguards compliant with article 5 of the European Convention on Human Rights

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¹ Hansard, HL Series 5, Vol. 797 col. 622, (24 April 2019) – The Baroness Thornton.

² Department of Health & Social Care, ‘Will-write letter’ from Minister of State for Care (10 June 2019) at data.parliament.uk/DepositedPapers/Files/DEP2019-0635/letter_from_Caroline_Dinenage_Liberty_Protection_Safeguards.pdf (unless otherwise stated, all URLs were last accessed on 19 July 2019).

³ The DoLS are contained in MCA schedules A1 and 1A. The LPS are contained in the new MCA schedule AA1.

(ECHR),⁴ the right to liberty and security of the person, for people who are deprived of their liberty in connection with arrangements to enable their care and treatment.

It is envisaged that the LPS will authorise an estimated 304,132 detentions annually in England and Wales.⁵ To put this into perspective: in 2018-19 there were just under 50,000 new detentions to provide inpatient treatment for mental disorder under the MCA's sister statute (the Mental Health Act 1983 MHA),⁶ the prison population in England and Wales stood at just over 82,000,⁷ and over 26,000 people passed through immigration detention.⁸ The new LPS will represent a high-water mark in the history of detention in the UK (Figure 1, below).

These are not 'paradigmatic' cases of deprivation of liberty.⁹ The affected population is predominantly older adults with dementia and people with intellectual disabilities, autism or brain injuries.¹⁰ A minority, less than 2%, will be receiving inpatient treatment for mental disorder in psychiatric hospitals.¹¹ Some will be treated for physical conditions in general or acute hospitals. The largest affected group will be in residential care or nursing homes.¹² More perplexingly, the LPS will also apply to tens of thousands of adults living in private homes, including 'supported living' accommodation and, in what is likely to be a source of growing social and political anxiety, some adults living with their families.¹³

Internationally, there is growing concern about the 're-institutionalisation' of disabled adults in community settings,¹⁴ with some states and international bodies beginning to

⁴ Convention for the Protection of Human Rights and Fundamental Freedoms (Council of Europe) 213 UNTS 222, ETS No 5, UN Reg No I-2889; [Opened for Signature] 4th Nov 1950, [Entered into Force] 3rd Sep 1953].

⁵ Department of Health and Social Care, 'Impact Assessment: Mental Capacity (Amendment) Bill (Revised IA, dated 31/01/2019): at <https://publications.parliament.uk/pa/bills/cbill/2017-2019/0323/MCAB%20Impact%20Assessment%20FINAL.rtf%20SIGNED.pdf>

⁶ NHS Digital, 'Mental Health Act Statistics' Annual Figures 2018-19: at <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures>

⁷ Ministry of Justice, HM Prison Service and Her Majesty's Prison and Probation Service, 'Official Statistics, Prison population figures 2018' (2019): at <https://www.gov.uk/government/statistics/prison-population-figures-2018>

⁸ Home Office, 'Immigration statistics, year ending March 2018' : at <https://www.gov.uk/government/statistics/immigration-statistics-year-ending-march-2018>

⁹ S.W. Stark, 'Deprivations of liberty: beyond the paradigm' (2019) (April) Public law [380-401].

¹⁰ NHS Digital, 'Supplementary information: DoLS activity by disability group during reporting period 2017-18' (2019): at <https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2019-supplementary-information-files/dols-activity-by-disability-group-during-reporting-period-2017-18>.

¹¹ In 2017-18, 5,260 DoLS applications in England were from 'mental health establishments' out of a total of 240,455 (2%). However, the LPS will apply to a larger population because it incorporates new settings and age groups. NHS Digital, 'Mental Capacity Act 2005, Deprivation of Liberty Safeguards England, 2018-19' (2019) at: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments/england-2018-19>. Equivalent data are not given for Wales: Care Inspectorate Wales and Healthcare Inspectorate Wales, 'Deprivation of Liberty Safeguards Annual Monitoring Report for Health and Social Care 2017-18' (2019), at: <https://careinspectorate.wales/deprivation-liberty-safeguards-annual-monitoring-report-health-and-social-care-2017-18>.

¹² Ibid.

¹³ Response to request for information from the Law Commission under the Freedom of Information Act 2000, 10 May 2019, available upon request from author.

¹⁴ N. Crowther, 'The right to live independently and to be included in the community in European States: ANED synthesis report' (*European Network of Academic Experts in the Field of Disability (ANED)*, 2019) at: <https://www.disability-europe.net/theme/independent-living>.

view this through the lens of detention.¹⁵ The LPS will be of interest to states contemplating regulatory responses to non-paradigmatic detentions. Whether they will improve upon the DoLS—which were regarded internationally as a cautionary tale¹⁶—remains to be seen.

The application of the detention paradigm to settings that have until very recently represented freedom in the community raises searching questions about how, and why, we have come to invoke this right in these contexts. These pressing questions are beyond the scope of this review; which considers the operational challenges of securing article 5 compliant safeguards on this scale. I outline the background to the DoLS and the LPS, before examining their provisions in greater detail and charting the key issues and debates that arose during the law reform process.

II. BACKGROUND

The MCA 2005 is an unlikely vehicle for the detention of over 300,000 people. Unlike the MHA it is not generally viewed as a 'compulsory power',¹⁷ and is often described domestically as 'empowering'.¹⁸ It provides a framework for making substitute decisions in the 'best interests' of a person considered to lack the 'mental capacity' to make a particular decision. Whereas the MHA includes a 'public protection' remit, the focus of the MCA is on the protection of the individual.

The MCA potentially applies to almost all decisions in a person's life; from what they eat for breakfast, to where they live, their relationships with others, and decisions about medical treatments. It is central to almost all aspects of the care and treatment of populations whose capacity may be in doubt.

A key characteristic of the MCA is its 'informality'. Even very serious medical and personal welfare decisions can potentially be made without the involvement of courts or formally appointed decision makers. Instead, caregivers can rely upon a 'general defence' against

¹⁵ W. Boente, 'Some Continental European Perspectives on Safeguards in the Case of Deprivation of Liberty in Health and Social Care Settings' (2017) (23) *International Journal of Mental Health and Capacity Law* [69-83]; Fritze, Chesterman, Grano, 'Designing a deprivation of liberty authorisation and regulation framework: Discussion paper' (Office of the Public Advocate, Victoria 2017); Victorian Law Reform Commission, 'Guardianship final report background paper: Legislative schemes regulating deprivation of liberty in residential care settings' (2012); Royal Commission into Aged Care Quality and Safety, 'Restrictive Practices in Residential Aged Care in Australia' (Background Paper 4, 2019) at: <https://agedcare.royalcommission.gov.au/>; UNHRC 'Report by Special Rapporteur on the Rights of Persons with Disabilities C Devandas Aguilar' UN Doc A/HRC/40/54, (11 January 2019) ; See also recent complaints brought to the CRPD Committee - *DR v Australia* (communication 14/2003) CRPD/C/17/D/14/2013), (19 May 2017); and also jurisprudence of the European Court of Human Rights, e.g. *Stanev v Bulgaria* (2012) 55 E.H.R.R. 22; [2012] M.H.L.R. 23. *DD v Lithuania* [2012] M.H.L.R. 209.

¹⁶ (Ibid) Victorian Law Reform Commission; (Ibid) Victoria Office of the Public Advocate, Fritze, Chesterman and Grano; Scottish Law Commission, Report on Adults with Incapacity (Scot Law Com No 240, 2014); C McKay and J Stavert, 'Scotland's Mental Health and Capacity Law: The Case for Reform' *Edinburgh Napier University* (2017) at: <http://www.napier.ac.uk/about-us/news/mentalwelfarecommission>; Department of Health (Ireland - An Roinn Sláinte), 'Deprivation of Liberty: Safeguard Proposals: Consultation Paper' (2017) at: <https://health.gov.ie/consultations/>

¹⁷ E.g. Wessely et al, 'Modernising the Mental Health Act' (Final report of the Independent Review of the Mental Health Act 1983) December 2018 [123].

¹⁸ E.g. Department for Constitutional Affairs, Mental Capacity Act Code of Practice (2007) [foreword by The Rt Hon. the Lord Falconer of Thoroton].

liability¹⁹, which codified the common law position that acts of care or treatment in the best interests of those lacking the capacity to consent can rely upon the doctrine of necessity.²⁰ This was viewed by the Law Commission in the 1990s as avoiding the stigma and 'bureaucracy' associated with mental health law, 'normalising' the care and treatment of people deemed to lack capacity.²¹ However, the defence has been described as operating in practice as a broad *de facto* power²² whilst providing few of the procedural safeguards commonly associated with compulsory powers.

The MCA contains a scheme of Independent Mental Capacity Advocacy (IMCAs)²³ and potential recourse to the Court of Protection, a superior court of record, in cases of doubt or dispute.²⁴ However, legal challenges to decisions made under the MCA are rare.²⁵

A. *The Bournemouth Case*

The government did not initially associate the MCA with detention when developing the Bill.²⁶ This changed in October 2004, at the Bill's second reading, when the European Court of Human Rights (ECtHR) ruled in *HL v UK*²⁷ that an autistic man who was 'informally' admitted to Bournemouth Hospital, apparently in his best interests and on grounds of necessity, had been unlawfully deprived of his liberty.

HL had been living in the community with his carers but had been taken to Bournemouth Hospital following agitated behaviour at his day centre. For historical reasons, the MHA is primarily used to formally detain patients who are regarded as 'objecting' to admission or treatment; it is rarely used for those who are regarded as compliant with admission and treatment.²⁸ HL was sedated, and although his behaviour indicated that he was very distressed²⁹ he was not regarded by clinicians as 'objecting' or attempting to leave. Without the provisions of the MHA, there was no obvious mechanism for his carers or relatives to seek to discharge him or challenge his informal admission. A claim was brought on HL's behalf seeking judicial review of the decision to 'detain' HL and a writ of *habeas corpus* to secure his discharge. The domestic courts approached the question of whether HL had been detained through the lens of the tort of false imprisonment, with the House of Lords concluding that he was not falsely imprisoned because he had not actually

¹⁹ MCA ss 5, 6.

²⁰ *Re F (Mental Patient: Sterilisation)* [1990] 2 A.C. 1; [1989] 2 WLR 1025.

²¹ Law Commission, *Mentally Incapacitated Adults and Decision-Making: An Overview* (Law Com No 119, 1991).

²² A. Ruck Keene, 'Powers, defences and the 'need' for judicial sanction' (2016) (Autumn) *Elder Law Journal* [244-52].

²³ MCA s35-41.

²⁴ MCA ss 15, 16.

²⁵ L. Series, P. Fennell and J. Doughty, 'Welfare cases in the Court of Protection: A statistical overview' *Cardiff University, Report for the Nuffield Foundation* (2017), at: <http://orca.cf.ac.uk/id/eprint/118054>.

²⁶ Lord Chancellor's Office, *Who decides? Making decisions on behalf of mentally incapacitated adults*, Cm 2803 (1997); Lord Chancellor's Office, 'Making Decisions' *The Government's proposals for making decisions on behalf of mentally incapacitated adults*, Cm 4465 (1999); Department for Constitutional Affairs, *Draft Mental Incapacity Bill*, Cm 5859 (2003).

²⁷ [2005] 40 E.H.R.R. 32; [2004] M.H.L.R 236 277.

²⁸ Recommendations of Lord Percy, *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency. 1954-1957*, Cmd 169 (1957).

²⁹ *HL v UK* n 27, at [39]; Health Service Ombudsman, 'Annual Report for 2001-2: Case No. E. 2280/98-99' (2001).

attempted to leave. Even if he had been so detained, they held that the hospital had a defence against liability under the common law doctrine of necessity.³⁰

HL's family and carers successfully pursued the case to the ECtHR, which rejected the distinction relied upon by the House of Lords between 'actual restraint' and 'restraint which was conditional upon his seeking to leave'.³¹ HL 'was under continuous supervision and control and was not free to leave', and was thus deprived of his liberty.³² Noting the dearth of regulation and safeguards for informal admissions, the Strasbourg Court found a violation of the article 5(1) ECHR requirement for a 'procedure required by law' and no effective means to challenge the detention before an appropriately constituted authority (namely a court/tribunal etc) as is required by article 5(4). HL's detention, and that of thousands like him, was therefore unlawful under the Convention.

B. The Deprivation of Liberty Safeguards

The government consulted on what to do about the estimated 100,000 adults in care homes and hospitals who fell within the so called 'Bournewood gap' following the ruling in *HL v UK*.³³ The majority of respondents opposed the use of the MHA for the affected population, which was primarily older adults with dementia and people with intellectual disabilities or autism, mainly on grounds of its perceived stigma. Thus, a parallel framework for authorising detention in care homes and hospitals—the DoLS—was inserted into the MCA in 2007.³⁴

The DoLS will be compared with the LPS in more detail below. In outline, 'managing authorities' of hospitals and care homes must recognise that patients or residents are deprived of their liberty and must apply to 'supervisory bodies' for authorisation. These are mainly local authorities; although in Wales, Local Health Boards (LHBs) function as supervisory bodies for hospital detentions. Supervisory bodies must send out a Best Interests Assessor (BIA) and a Mental Health Assessor (MHA) to assess whether six 'qualifying requirements' for detention under the DoLS are met. If all are met, the supervisory body must authorise the detention. Additional safeguards available to the 'relevant person' include the appointment of a 'Relevant Person's Representative' (RPR), usually from amongst their family and friends, potentially an IMCA (as well as or instead of an RPR), reviews by the supervisory body and the right to seek a judicial review of the authorisation from the Court of Protection under s21A MCA.

³⁰ *R. v Bournewood Community and Mental Health NHS Trust Ex p. L* [1999] 1 A.C. 458; [1998] 3 W.L.R. 107.

³¹ *HL v UK* n27, at [90].

³² *HL v UK* n27, at [91].

³³ Department of Health, 'Bournewood' Consultation' (2005); Department of Health, 'Protecting the Vulnerable: the "Bournewood" Consultation: Summary of Responses' (2006).

³⁴ MCA Schedules A1 and 1A, inserted via the Mental Health Act 2007.

The DoLS are regarded as 'very much the poor relation of the MHA':³⁵ notorious for their complexity,³⁶ with administrative costs double that of the impact assessment³⁷ and eye-wateringly expensive litigation.³⁸ Yet they did not provide an effective means to challenge detention when the detained person, or those close to them, objected.

The widely reported case of Steven Neary illustrates the difficulties.³⁹ Neary is an autistic man with intellectual disabilities who had been living with his father, with support funded by the London Borough of Hillingdon. Following a temporary stay in respite care, Hillingdon moved Neary into a 'positive behaviour unit' (a registered care home) against his wishes and those of his father. A litany of failures followed, including: an initial failure to even seek a DoLS authorisation, a long delay in appointing an IMCA to support Steven and his father (who was RPR), and a failure to seriously consider Steven's own wishes and feelings in assessments. It was almost a year before the case reached the Court of Protection, in part because the council misled the family that it was planning to return Steven home, and in part because Steven's father was scared that if he 'rocked the boat' the council might review Steven's entitlements to support if he returned home.⁴⁰ The Court of Protection discharged the authorisation, meaning Steven could return home, and found violations of both article 5 and rights to respect for home, family and private life under article 8 ECHR.

Neary established the principle that disagreements over 'significant welfare issues' that cannot be resolved by other means should be urgently placed before the Court of Protection.⁴¹ There is a positive obligation on the state to ensure that a person is '*not only entitled but enabled* to have the lawfulness of his detention reviewed speedily by a court' (emphasis added).⁴² Following *Neary*, other local authorities have been criticised for using the DoLS to remove people from their homes and families, sometimes restricting contact with loved ones, without ensuring these disputes are speedily brought to court.⁴³ Overall, the rate of appeal under the DoLS is around one per cent,⁴⁴ whereas the number of people

³⁵ R. Jones, 'Deprivations of Liberty: Mental Health Act or Mental Capacity Act?' (2007) (16) Journal of Mental Health Law 170-74, [170]. See also: P. Bowen, Blackstone's Guide to The Mental Health Act 2007 (Oxford: OUP 2007); R. Hargreaves, 'The Deprivation of Liberty Safeguards - essential protection or bureaucratic monster?' (2009) (19) Journal of Mental Health Law 117-27; M. Gunn, 'Hospital treatment for incapacitated adults', (2009) (17) (2) Medical Law Review, 274-81.

³⁶ *C v Blackburn and Darwen Borough Council* [2011] EWHC 3321 (Fam), at [24]; [2012] M.H.L.R. 202. House of Lords Select Committee on the Mental Capacity Act 2005, Report of Session 2013-14 (Mental Capacity Act 2005: post-legislative scrutiny) (HL 139), at [271].

³⁷ A. Shah and others, 'Deprivation of Liberty Safeguards in England: implementation costs', (2011) (199) (3) British Journal of Psychiatry, [232-38].

³⁸ L Series, P Fennell and J Doughty, n25.

³⁹ *London Borough of Hillingdon v Neary* [2011] EWHC 1377 (COP) [2011] 4 All E.R. 584; [2011] M.H.L.R. 404

⁴⁰ *Ibid*, at [146].

⁴¹ *Ibid*, at [33].

⁴² *Ibid*, at [202].

⁴³ *Somerset v MK (Deprivation of Liberty: Best Interests Decisions: Conduct of a Local Authority)* [2014] EWCOP B25; *Essex County Council v RF (Deprivation of Liberty and damage)* [2015] EWCOP 1; *Milton Keynes Council v RR* [2014] EWCOP B19; *SR v A Local Authority* [2018] EWCOP 36; Local Government Ombudsman, 'The Right to Decide: Towards a greater understanding of mental capacity and deprivation of liberty' (2017) [1], at: <http://collateral2.vuelio.co.uk/RemoteStorage/LGO/Releases/1176/DOLS%20AND%20MCA%20-%20EMB.pdf>.

⁴⁴ This is the rate of appeals per standard authorisation; the rate of appeals against emergency authorisations would be far lower.

who are said to be objecting to their confinement is estimated to be around 30 per cent.⁴⁵ There is a strong likelihood that when the person, or those close to them, objects to detention under the DoLS, they are not reliably able to exercise Article 5(4) ECHR rights of challenge.

In 2013-14 the House of Lords Select Committee on the MCA conducted post-legislative scrutiny of the 2005 Act.⁴⁶ Whilst finding that the MCA continues to be held in 'high regard', the Committee concluded the DoLS were 'poorly drafted, overly complex' and 'far from being used to protect individuals and their rights, they are sometimes used to oppress individuals'.⁴⁷ It called upon the government to 'start again'.⁴⁸

C. Cheshire West

The DoLS authorise 'deprivation of liberty'⁴⁹, defining this by direct reference to article 5 ECHR.⁵⁰ When the DoLS were inserted into the MCA, the Joint Committee on Human Rights (JCHR) and others had called for a statutory definition, but the government had refused on the basis that it was 'not possible' to supply one.⁵¹ Managing authorities and supervisory bodies adopted their own working definitions of 'deprivation of liberty', resulting in low and highly variable application rates. By 2014, it was believed that thousands of adults were unlawfully detained.⁵²

It is not necessary to define deprivation of liberty in order to authorise it (the MHA does not). An alternative approach would be to define a list of triggering circumstances when the safeguards must apply. This was at one point suggested by the Law Commission in their proposals to reform the DoLS (below).⁵³ This approach requires engagement with the elusive question posed by Peter Bartlett: what are the DoLS actually *for?*, beyond the circular answer of providing deprivation of liberty safeguards.⁵⁴ The meaning of article 5 is a technical lawyers' question, ultimately determined by the courts. Asking where safeguards would be necessary, beneficial or potentially counterproductive is a fundamentally more democratic question, requiring stakeholder consultation and parliamentary debate.⁵⁵

⁴⁵ Department of Health and Social Care, Mental Capacity (Amendment) Bill: Impact Assessment (2018) 1.

⁴⁶ Mental Capacity Act 2005: post-legislative scrutiny, n36.

⁴⁷ *Ibid*, 7.

⁴⁸ *Ibid*.

⁴⁹ MCA Sched A1, s 1-3.

⁵⁰ MCA s64(5), as amended.

⁵¹ JCHR Fourth Report of Session 2006-07 (Legislative Scrutiny: Mental Health Bill) (HC 288, HL 40) at [84] and Appendix 3 [52] for government's response.

⁵² HL 139 (2014) n36, [7]; Care Quality Commission, 'Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2012/13' (2014) at <http://www.cqc.org.uk/public/news/protecting-people%E2%80%99s-human-rights-when-they-cannot-consent-treatment>.

⁵³ Law Commission, Mental capacity and deprivation of liberty: A consultation paper (Consultation Paper 222, 2015) Provisional proposals 7-2 – 7-4.

⁵⁴ P. Bartlett, 'Reforming the deprivation of liberty safeguards (DoLS): What is it that we want?' (2014) 20 (3) *Web Journal of Current Legal Issues*, <http://webjcli.org/article/view/355>.

⁵⁵ A. Ruck Keene, written evidence to the JCHR's 2018 inquiry into The Right Freedom and Safety, at: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/human-rights-committee/the-right-to-freedom-and-safety-reform-of-the-deprivation-of-liberty-safeguards/written/80869.pdf>.

The result of leaving the scope of the DoLS to the courts was, inevitably, near-continuous litigation on this issue. By 2014 a series of confusing, sometimes contradictory and controversial rulings had defined deprivation of liberty so narrowly that even a man who had broken down the door of a care home attempting to escape,⁵⁶ and a woman wanting to leave a care home to return to her own home,⁵⁷ were found not to be deprived of their liberty. Thus, the Supreme Court ruling in *P v Cheshire West and Chester Council and another; P and Q v Surrey County Council*⁵⁸ on the meaning of 'deprivation of liberty' in connection with care arrangements for people considered unable to consent to their care arrangements was keenly awaited.

The *Cheshire West* case concerned three people with intellectual disabilities living, variously, in a 'small NHS facility', a shared apartment with support, and with a foster parent. Being neither hospitals nor registered adult care homes, these were outside the limited scope of the DoLS, meaning authorisation would require costly annual court applications.⁵⁹ Delivering the leading judgment, Lady Hale relied upon what she took to be the ratio in *HL v UK* and later cases before the ECtHR,⁶⁰ holding that the 'acid test' of deprivation of liberty is whether a person is subject to continuous supervision and control and not free to leave.⁶¹ That they are not objecting, that the arrangements are the least restrictive possible and in their best interests, or 'normal' for a person with a similar condition, is irrelevant to the question of whether they are deprived of their liberty (but relevant to whether it is justified).

Whether *Cheshire West* is a landmark human rights victory or a perverse interpretation of article 5 ECHR is hotly debated.⁶² Its practical consequences, however, are undeniably challenging. Within a year of the 2014 judgment, the volume of DoLS applications increased by more than a factor of ten and continued to rise, as depicted in Figure 1. In 2018-19 supervisory bodies in England received 240,455 DoLS applications and they had acquired a backlog of over 131,350 unprocessed applications.⁶³ The Association of

⁵⁶ *C v Blackburn and Darwen Borough Council*, n36.

⁵⁷ *CC v KK and STCC* [2012] EWHC 2136 (COP) at [99] [2012] C.O.P.L.R. 627.

⁵⁸ [2014] UKSC 19; [2014] A.C. 896.

⁵⁹ *Salford City Council v BJ (Incapacitated Adult)* [2009] EWHC 3310 (Fam); [2010] M.H.L.R. 283.

⁶⁰ *Stanev v Bulgaria*; *D.D. v Lithuania*, n15; *Kędzior v Poland* [2013] M.H.L.R. 115; BAILII 2012 ECHR 1809; *Mihailovs v Latvia* [2014] M.H.L.R. 87; BAILII 2013 ECHR 65.

⁶¹ *Cheshire West*, n 58, at [48]-[49].

⁶² E.g. I. Burgess, 'We should welcome this Supreme Court ruling- it enshrines social work values in law' Community Care (London, 12 September 2014); Care Quality Commission, Monitoring the use of the Mental Capacity Act Deprivation of Liberty Safeguards in 2013-14 (2015); D. Whitaker, 'Social justice for safeguarded adults deprived of their liberty in the United Kingdom?' (2014) (29) (9) Disability & Society 1491-95; N Allen, 'The (not so) great confinement' (2015) (March) Elder Law Journal, 45-52; J. Holbrook, 'A distorted view' (2014) 164 (7605) New Law Journal[7-9]; Hewson B, 'How UK judges forgot the meaning of "liberty"' (Spiked 2014) <http://www.spiked-online.com/newsite/article/how-uk-judges-forgot-the-meaning-of-liberty/14840#.UzIH4vidU41>.

⁶³ NHS Digital (2019); Care Inspectorate Wales and Healthcare Inspectorate Wales (2018), n 11.

Directors of Adult Social Services produced a 'priority tool'⁶⁴ to help supervisory bodies work out—in the words of the JCHR—'how best to break the law'.⁶⁵

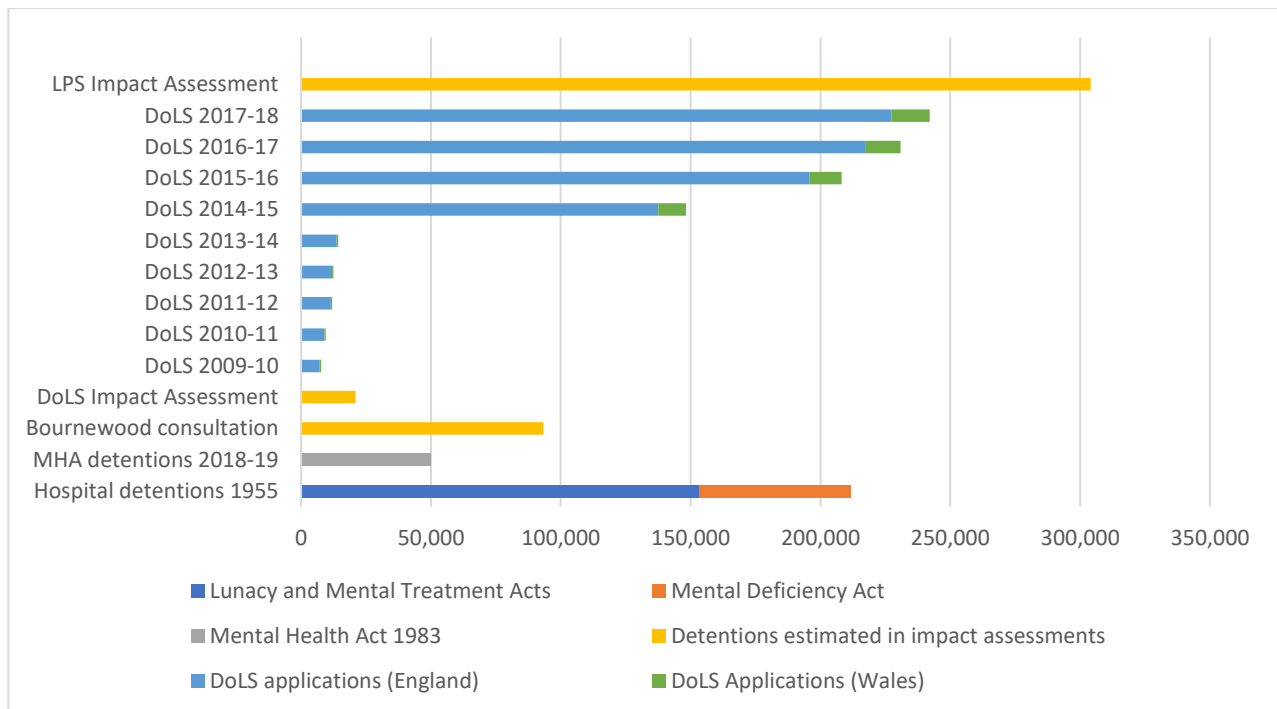


Figure 1 Estimated and actual annual detentions under the MHA, the DoLS and the LPS⁶⁶

Following *Cheshire West* an estimated 53,000 people outside the scope of the DoLS scheme will require safeguards.⁶⁷ This acid test encompasses people in supported living schemes, as well as people in private homes, receiving publicly or privately arranged care, or even care delivered by families themselves, known as 'domestic DoLS'.⁶⁸ The judgment also means that thousands of 16 and 17 year olds and other children in the care of the State would require detention safeguards.⁶⁹ The Law Commission estimated that if these

⁶⁴ Association of Directors of Adult Social Services, 'A Screening tool to prioritise the allocation of requests to authorise a deprivation of liberty' (2016) <https://www.adass.org.uk/adass-priority-tool-for-deprivation-of-liberty-requests/>.

⁶⁵ JCHR, Seventh Report of Session 2017–19 (The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards) (HC 890, HL 161) (2018) [3]. See also: Local Government Ombudsman, 'Investigation into a complaint against Staffordshire County Council (reference number: 18 004 809)' (2019).

⁶⁶ It is not possible to give the actual detention rate for DoLS because so many applications remain unprocessed, hence the application rate is given here. Data sources: DoLS statistics from annual reports available on NHS Digital, at: <https://digital.nhs.uk>; statistics on the Lunacy and Mental Treatment and Mental Deficiency Acts from appendices of Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, n 28; data from impact assessments for the Bournemouth consultations (n 33) and the Mental Capacity Amendment Bill (n 5); MHA detentions data from NHS Digital (n 6).

⁶⁷ 'Impact Assessment: Mental Capacity (Amendment) Bill' (2019) n 5.

⁶⁸ *Rochdale MBC v KW* [2014] EWCOP 45; [2015] 2 F.C.R. 244 [2015] Med. L.R. 19. *The London Borough of Tower Hamlets v TB & Anor* [2014] EWCOP 53; [2015] C.O.P.L.R. 87. *Rochdale Metropolitan Borough Council v KW & Ors* [2015] EWCOP 13; [2015] 2 F.C.R. 255. *KW & Ors v Rochdale MBC* [2015] EWCA Civ 1054; [2016] 1 W.L.R. 198. *Staffordshire CC v SRK & Ors* [2016] EWCOP 27; [2016] 3 W.L.R. 867; [2016] Fam. 419. *SSJ v Staffordshire CC & Ors* [2016] EWCA Civ 1317; [2017] 2 W.L.R. 1131 [2017] C.O.P.L.R. 120. *Haringey LBC v R* [2016] EWCOP 33; [2016] C.O.P.L.R. 476 *W City Council v L* [2015] EWCOP 20; [2015] C.O.P.L.R. 337. *SCC v MSA & Anor* [2017] EWCOP 18.

⁶⁹ *Re Daniel X* BAILII 2016 EWFC B31; *A Local Authority v D* [2015] EWHC 3125 (Fam); *Northumberland County Council v MD, FD and RD* BAILII 2018 EWFC 47; *Trust A v X and A Local Authority* [2015] EWHC 922

populations were given safeguards compliant with article 5 ECHR (which they were not),⁷⁰ the overall cost of the existing scheme would exceed £2bn a year.⁷¹ The father of Steven Neary subsequently told the JCHR that the Council that had unlawfully detained him now sought authorisation for alleged deprivation of liberty in his own home.⁷²

An analysis of *Cheshire West* is beyond the scope of this article,⁷³ but it was the key precipitating factor for the extraordinary increase in detentions under the MCA and the operational challenges facing both DoLS and the LPS. Its underpinning policy rationale, spelled out by Lady Hale, was that if the appellants were not found to be 'deprived of their liberty'—then—'no independent check is made' on whether their care arrangements are in their best interests.⁷⁴ The 'extreme vulnerability' of the affected population means we should 'err on the side of caution' when deciding what constitutes a deprivation of liberty.⁷⁵

It might plausibly be argued that *Cheshire West* was a legal response to the minimal procedural safeguards available under the MCA and wider concerns about the provision of adult social care.

D. The Law Commission

The government asked the Law Commission to review the DoLS. They concluded the DoLS were indeed broken and in need of reform: too complex, too inflexible, their scope too limited, with a lack of oversight and effective safeguards.⁷⁶ The DoLS were too narrowly focussed on article 5—'a technical legal solution to a technical legal problem'⁷⁷—when the key substantive issues were better captured by article 8 ECHR—rights to enjoyment of home, family and private life.

The Commission's initial proposals for two tiers of safeguards, promoting a wider range of rights, were scaled back to a framework for authorising deprivation of liberty—the LPS—and modest amendments to the MCA.⁷⁸ To align the MCA more closely to the UN Convention on the Rights of Persons with Disabilities (CRPD),⁷⁹ the Commission proposed

(Fam); *A Local Authority v D* [2015] EWHC 3125 (Fam); *Re D (A Child)* [2017] EWCA Civ 1695; *Re D (A Child)* [2019] UKSC 42.

⁷⁰ A McNicoll, 'Councils' failure to make court applications leaving 'widespread unlawful deprivations of liberty' a year after Cheshire West ruling' Community Care (London, 17 June 2015) at: <https://www.communitycare.co.uk/2015/06/17/councils-failure-make-court-applications-leaving-widespread-unlawful-deprivations-liberty-year-cheshire-west-ruling/>.

⁷¹ Law Commission, *Mental Capacity and Deprivation of Liberty* (Law Com No 372, 2017).

⁷² JCHR, *The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards*, n 65.

⁷³ I discuss the judgment in L Series, 'Making sense of Cheshire West' in Claire Spivakovsky, Linda Steele and Penelope Weller (Eds) *The Legacies of Institutionalisation: Disability, Law and Policy in the 'Deinstitutionalised' Community* (Hart forthcoming 09-07-2020).

⁷⁴ *Cheshire West*, n 58, at [1], see also [32].

⁷⁵ *Ibid*, at [57].

⁷⁶ Law Commission (2015) n 53.

⁷⁷ *Ibid*, at [2.15], citing P. Bartlett n 54.

⁷⁸ Law Com (2017), n 71.

⁷⁹ Analysis of article 12 CRPD is beyond the scope of this paper, but see: P. Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law' (2012) 75 (5) *Modern Law Review*, 752-78; R. Harding, 'The Rise of Statutory Wills and the Limits of Best Interests Decision-Making in Inheritance' (2015) 78 (6) *Modern Law Review*, 945-70; E. Jackson, 'From 'Doctor Knows Best' to Dignity: Placing Adults Who Lack Capacity at the Centre of Decisions About Their Medical Treatment', (2018) 81 (2)

placing 'particular weight' on the wishes and feelings of the person in best interests decisions,⁸⁰ and a statutory framework for supported decision making.⁸¹ As an intermediate safeguard, they recommended that the general defence should only be available for very serious decisions if certain information were recorded.⁸² They also proposed a new tort of unlawful deprivation of liberty,⁸³ and provisions for 'advance consent' to a potential deprivation of liberty.⁸⁴ Subsequently the JCHR largely endorsed the Law Commission's approach.⁸⁵

E. The Mental Capacity (Amendment) Bill

In July 2018 the Mental Capacity (Amendment) Bill⁸⁶ was tabled in the House of Lords. There had been no further public consultation, yet the Bill differed from the Law Commission's proposals in important respects.⁸⁷ The government estimated the 'adjusted' LPS scheme in the Bill would save over £200m per year,⁸⁸ whilst improving and extending existing safeguards and fixing an overwhelmed system. Even the Minister responsible—Lord O'Shaughnessy—commented that this sounded almost 'too good to be true'.⁸⁹

To the dismay of organisations representing disabled people, the scope of the Bill was narrowly focused on article 5 ECHR, without the amendments to bring the MCA closer to the CRPD.⁹⁰ Gone too was the tort of unlawful deprivation of liberty, provisions for advance consent and requirements for a written record for serious decisions. The government's Bill was considerably shorter than the Law Commission's, with many clauses and provisions omitted.⁹¹ The government insisted that key operational details could be included in the

Modern Law Review, 247-81; L. Series, *'The Place of Wishes and Feelings in Best Interests Decisions: Wye Valley NHS Trust v Mr B'* (2016) 79 (6) Modern Law Review, 1101-15.

⁸⁰ Law Com No 372, n 71, recommendation 40.

⁸¹ Ibid, recommendation 42.

⁸² Ibid, recommendation 41.

⁸³ Ibid, recommendation 45.

⁸⁴ Ibid, recommendation 43.

⁸⁵ JCHR, *The Right to Freedom and Safety*, n 65.

⁸⁶ Information about the Bill's progress, including different versions of the Bill, amendments, links to debates in Hansard, Ministerial 'will write' letters and other supporting documentation can be found on its parliamentary website: <https://services.parliament.uk/Bills/2017-19/mentalcapacityamendment.html>.

⁸⁷ Compare and contrast: HM Government, 'Final Government Response to the Law Commission's review of Deprivation of Liberty Safeguards and Mental Capacity' (Department of Health and Social Care written statement, 14th March 2018) at <http://qna.files.parliament.uk/ws-attachments/861932/original/180314%20Response%20to%20Law%20Commission%20on%20DoLS%20-%20final.pdf>; Department of Health and Social Care, 'Annex A: Law Commission recommendations and Government Responses' (Attached to 'will write' letter from Lord O'Shaughnessy to peers dated 24/07/18) at http://data.parliament.uk/DepositedPapers/files/DEP2018-0796/Annex_A_Law_Commission_Recommendation_and_govt_action.pdf.

⁸⁸ Mental Capacity (Amendment) Bill (Revised IA, dated 31/01/2019, 2019) n 5.

⁸⁹ Hansard, HL Series 5, (2nd Reading) Vol 792 col 1106 (16 July 2018).

⁹⁰ See written evidence of People First and Inclusion London to the Public Bill Committee (MCAB46) (n 86), and G. Loomes, 'The Mental Capacity Legislation and Our Human Rights' Report commissioned by Inclusion London, 2019) at: <https://www.inclusionlondon.org.uk/uncategorised/inclusion-londons-report-mental-capacity-and-our-human-rights/>.

⁹¹ The Law Commission's draft Bill was 33 pages long (Appendix A, Law Commission No 372, n 71). The Bill as introduced in July 2018 (HL Bill 117, n 86) was only 25 pages long.

Code of Practice, despite recent confirmation that the MCA's codes cannot *create* legal obligations that are not already established via other sources of law.⁹²

The Bill was heavily criticised by stakeholders, including: professional bodies,⁹³ local government,⁹⁴ care providers,⁹⁵ civil rights organisations,⁹⁶ and organisations representing older and disabled people.⁹⁷ Almost 200,000 people signed a petition calling for better protection of the rights of disabled people.⁹⁸ Peers declared the Bill 'one of the worst pieces of legislation ever brought before this House'.⁹⁹

⁹² *An NHS Trust & Ors v Y & Anor* [2018] UKSC 46; [2019] A.C. 978, at [97].

⁹³ British Association of Social Workers, 'BASW England response to the Mental Capacity (Amendment) Bill' (October 2018) at <https://www.basw.co.uk/media/news/2018/oct/basw-england-response-mental-capacity-amendment-bill>; Association of Directors of Adult Social Services, 'The Mental Capacity (Amendment) Bill – ADASS Statement – 4th September 2018', at: <https://www.adass.org.uk/adass-responds-to-mental-capacity-amendment-bill>; Law Society, 'Parliamentary briefing: Mental Capacity (Amendment) Bill – House of Lords committee stage' (2018) at <https://www.lawsociety.org.uk/policy-campaigns/public-affairs/parliamentary-briefing/parliamentary-briefing-mental-capacity-amendment-bill-hol-committee-stage/>. See evidence submitted to the Public Bill Committee (n 86) by the British Medical Association, Royal College of Psychiatrists, Royal College of Nursing, and the Royal College of Speech and Language Therapists.

⁹⁴ Local Government Association, 'Briefing: The Mental Capacity (Amendment) Bill Committee stage, House of Lords' (5 September 2018), at: <https://www.local.gov.uk/sites/default/files/documents/LGA%20briefing%20-%20The%20Mental%20Capacity%20%28Amendment%29%20Bill%20-%20CMTTEE%20HL%20-%2005092018%20FINAL.pdf>.

⁹⁵ These were largely led by the Voluntary Organisations Disability Group and Care England, see for example: 'A cross-sector representation of issues and concerns relating to the Mental Capacity (Amendment) Bill HL' (October 2018), with 16 signatories, at: <https://www.vodg.org.uk/news/leading-social-care-interest-groups-warn-government-that-its-mental-capacity-reforms-are-not-fit-for-purpose/>; Care England, Conflict of Interest (2018) < <http://www.careengland.org.uk/news/conflict-interest-0> ; Dimensions, 'Dimensions briefing on the Mental Capacity (Amendment) Bill (16 July 2018)' (2018) at <https://www.dimensions-uk.org/press-release/mental-capacity-amendment-bill-briefing/>; Care England, Conflict of Interest (2018) <http://www.careengland.org.uk/news/conflict-interest-0>.

⁹⁶ Liberty, 'To protect vulnerable people, the government must fix the Mental Capacity Amendment Bill' (14 January 2019), at: <https://www.libertyhumanrights.org.uk/news/blog/protect-vulnerable-people-government-must-fix-mental-capacity-amendment-bill>.

⁹⁷ Age UK, 'Briefing: Mental Capacity (Amendment) Bill (HL) Committee Stage – October 2018', at: <https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/age-uk-briefing---mental-capacity-amendment-bill-hl-committee--stage---august-18.pdf>; Inclusion London, 'Inclusion London's Briefing on the Mental Capacity Amendment Bill' (September 2018), at: <https://www.inclusionlondon.org.uk/wp-content/uploads/2018/09/Briefing-on-the-Mental-Capacity-Amendment-Bill-for-DDPOs.pdf>; 'Mental Capacity Act (Amendment) Bill Briefing from Third sector Second Reading [Commons]', signed by Mencap, National Autistic Society, Mind, Rethink Mental Illness, Alzheimer's Society, VoiceAbility, Disability Rights UK, POHWER, Parkinson's UK, BIHR, Sense, Liberty, Learning Disability England, the Disabled Children's Partnership and the Challenging Behaviour Foundation, at: <http://www.edgetraining.org.uk/wp-content/uploads/2018/12/Mental-Capacity-Bill-Third-sector-briefing-2R-debate-18.12.2018-1.pdf>. See also the evidence submitted by the Relatives and Residents Association, Inclusion London and People First, Independent Age, Rethink Mental Illness, Mencap, Learning Disability England and others to the Public Bill Committee (n 86); Mind, 'A quick look at the draft Liberty Protection Safeguards', at: <https://www.mind.org.uk/news-campaigns/legal-news/legal-newsletter-september-2018/mental-capacity-act-amendment-bill/> (visited 11 April 2019); Disability Rights UK, 'Social care sector unites in condemning Mental Capacity (Amendment) Bill' (8 February 2019), at: <https://www.disabilityrightsuk.org/news/2019/february/mentalcapacitybillopenletter>.

⁹⁸ 'To: Caroline Dinéage, Minister of State for Care and the UK government: Protect the human rights of people receiving care and support' (38 Degrees petition, created by the Reclaiming Our Futures Alliance), at: <https://you.38degrees.org.uk/petitions/promoted/protect-the-human-rights-of-people-receiving-care-and-support>.

⁹⁹ Hansard, HL Series 5, Vol 794 col 1247 (12 November 2019) (The Baroness Barker).

The Bill proceeded in haste. Parliamentarians complained of excessively short sitting times and insufficient time to consider government amendments.¹⁰⁰ It progressed in parallel to an independent review of the MHA,¹⁰¹ meaning many key matters about the relationship of detention under the MCA to mental health law were debated before the review had made its final recommendations.¹⁰² Accessible materials on the Bill for disabled people were produced too late in the Parliamentary process for any significant contributions to amendments or debate.¹⁰³ Key decisions—for example, over whether to include a statutory definition of deprivation of liberty—were made so late the Bill entered ‘Ping Pong’¹⁰⁴. Considerable energy was expended fighting major problems, such as the ‘care home arrangements’, whilst issues that emerged later around advocacy, renewals, and ‘domestic’ deprivation of liberty received limited attention. The government maintained there was an urgent need for action following *Cheshire West*.¹⁰⁵ But the frantic pace of the Bill could also be explained by fears that it would be overtaken by wider political events connected with Brexit.¹⁰⁶

III. THE (ADJUSTED) LIBERTY PROTECTION SAFEGUARDS

The main distinguishing characteristic of the LPS from the DoLS is their flexibility in where and how they operate. Greater flexibility is necessary to cope with the scale and diversity of deprivation of liberty following *Cheshire West*, yet this inevitably inserts complexity, discretion and the potential dilution of safeguards.

A. From ‘Accommodation’ to ‘Arrangements’

The DoLS construct deprivation of liberty as a function of being ‘accommodated’ in a care home or hospital.¹⁰⁷ The LPS deal instead with ‘arrangements’ to ‘enable’ care or treatment that ‘give rise to’ a deprivation of liberty.¹⁰⁸ The authorisation of ‘arrangements’ is more fluid, applying to potentially any setting, multiple settings, and transfers between settings. The Commission hoped this would give responsible bodies greater control over ‘the ways in which a person may justifiably be deprived of liberty’,¹⁰⁹ instead of approaching

¹⁰⁰ E.g. Hansard, HL 5 Series Vol 794 col 593 (27 November 2018); Hansard, HC 6 Series Vol 651 col 731 – and col 754 (18 December 2018); Hansard, HC Public Bill Committee (1st Sitting) col 10 (15 January 2019); Hansard, HC Public Bill Committee (6th Sitting) col 186 (22 January 2019); Hansard, HC Series 6 (Report Stage) Vol 654 col 847 (12 February 2019).

¹⁰¹ ‘Modernising the Mental Health Act’, n17.

¹⁰² Ibid. The review was published on 6 December 2018, at which point the Bill was approaching its third reading in the House of Lords.

¹⁰³ Department of Health and Social Care, ‘Mental Capacity (Amendment) Bill: easy read’ (published 31 January 2019) at: <https://www.gov.uk/government/publications/mental-capacity-amendment-bill-easy-read>; Department of Health and Social Care, Equality Analysis: Liberty Protection Safeguards – Mental Capacity (Amendment) Bill (published 17 December 2018) <https://www.gov.uk/government/publications/mental-capacity-amendment-bill-equality-analysis>.

¹⁰⁴ This is a process in the UK Parliament where amendments are passed back and forth between the House of Commons and the House of Lords until agreement can be reached.

¹⁰⁵ Hansard, HC Series 6 (2nd Reading) Vol 651 cols 730 and 756 (18 December 2018).

¹⁰⁶ Such as the collapse of the Government, the proguing of Parliament or the urgent need for legislation to address matters connected with exiting the European Union.

¹⁰⁷ E.g. MCA Sched A1 s15; MCA Sched A1 s20(1).

¹⁰⁸ MCA Sched AA1 s2.

¹⁰⁹ Law Com 372 (n 71) at [1.29].

detention as a binary question.¹¹⁰ For example, authorising arrangements involving one set of restrictions, but not others.¹¹¹

The drafters of the LPS envisioned a 'bright line' distinction between the arrangements to enable care and treatment that give rise to a deprivation of liberty, and the underlying care and treatment decisions themselves. The LPS can only authorise the former, whilst care and treatment decisions would continue to be made informally under the general defence¹¹², or by attorneys or deputies. The MHA also distinguishes between authorisation of detention and treatment,¹¹³ but the need for assessment or treatment is still built into the admission and review criteria.¹¹⁴ It is unclear how far assessments, reviews and legal challenges under the LPS must take underlying care and treatment decisions as an indisputable starting point for the arrangements, with the only question left for the LPS to resolve whether the person should be deprived of their liberty to achieve these, or whether care and treatment decisions can themselves be scrutinised within the LPS processes. It may not always be conceptually or practically straightforward to distinguish care and treatment decisions from the arrangements to enable these. This issue will be revisited below.

B. The Authorisation Process

Article 5(1) requires deprivation of liberty to be in accordance with 'fair and proper procedures' executed 'by an appropriate authority'.¹¹⁵ The DoLS procedure required managing authorities of care homes and hospitals to apply to supervisory bodies for authorisation of a deprivation of liberty. This often led to a 'carousel',¹¹⁶ where public bodies commissioned care or treatment then required managing authorities to seek authorisation from them for it. The LPS seek to 'streamline' assessments into existing care and treatment planning processes.¹¹⁷ Local authorities, NHS hospitals, clinical commissioning groups (CCGs) and LHBs serve as 'responsible bodies' where they provide or commission the care themselves.¹¹⁸ They may authorise the arrangements provided they are satisfied that the LPS apply,¹¹⁹ the authorisation conditions are met, and they comply with the procedural requirements described below.¹²⁰

Some administrative burdens will therefore be redistributed from local authorities to other NHS bodies. However, local authorities will still receive the highest proportion of applications; both because they commission the greatest number of care placements and

¹¹⁰ Ibid, [9.7].

¹¹¹ This may potentially operate in a similar way as the power of the supervisory body to set conditions on a DoLS authorisation: MCA Sch A1 s 53.

¹¹² Law Com 372 (n71) at [10.14]. See also: Department of Health and Social Care, 'Mental Capacity (Amendment) Act 2019: Explanatory Notes' (2019) at [35], <http://www.legislation.gov.uk/ukpga/2019/18/notes/contents>.

¹¹³ MHA 1983 Part IV.

¹¹⁴ E.g. s2(2)(a) MHA, s3(2)(a) s3(2)(d); s72(1)(a)(i), s72(1)(b)(i), s71(1)(b)(ii) MHA.

¹¹⁵ *Winterwerp v the Netherlands* (1979-80) 2 E.H.R.R. 387, at [45].

¹¹⁶ Law Com 372, n 71, at [1.27].

¹¹⁷ E.g. under the Care Act 2014; the Social Services and Well-being Act 2014; or the NHS Act 2006.

¹¹⁸ MCA Sch AA1, ss 6-12.

¹¹⁹ The test of whether the LPS 'applies' concerns its interface with the MHA, provided for by Part 7 of Schedule AA1 and discussed below.

¹²⁰ MCA Sch AA1, s17-18.

because the hierarchical approach adopted¹²¹ leaves them with responsibilities for privately arranged care, care provided informally by friends or family, and—owing to concerns about financial conflicts of interest—independent hospitals.

C. Care Home Arrangements

The largest proportion of DoLS and LPS applications concern people living in residential care.¹²² The government's 'adjusted'¹²³ LPS model introduced a new and separate procedure for authorising arrangements in residential care settings: the 'care home arrangements'.¹²⁴ The care home arrangements flow from the desire to 'streamline' the LPS into existing care planning processes, and relieve pressure on local authorities.

The government's initial idea was that care home managers could take on some functions otherwise performed by the responsible body, albeit with local authorities as responsible bodies still holding overall responsibility for issuing the authorisation. Care home managers were to arrange all LPS assessments themselves and make certain critical decisions around representation and advocacy. The responsible body would conduct a pre-authorisation review based on a statement by the care home manager.¹²⁵ Yet, the government assured care providers it would be the responsible body who would be liable if things went wrong.¹²⁶

The care home arrangements were not consulted upon by the government. Professional bodies, local government bodies and care providers themselves expressed concerns about financial conflicts of interest, the competence and ability of care homes to conduct the relevant assessments, and the impact of these additional responsibilities on an already struggling sector.¹²⁷ No additional resources were allocated for this assessment and administration role.¹²⁸ There were concerns that care homes might pass these costs on to residents.¹²⁹

The government initially argued that LPS assessments by the responsible body would 'duplicate' those already being undertaken by care homes.¹³⁰ Yet more than half of all care home placements are at least partially funded and arranged by local authorities or the NHS¹³¹, ergo reintroducing the 'carousel' the Commission had sought to remove. Furthermore, the assessments undertaken for the LPS are distinct from those undertaken by care homes for operational purposes. Simply put, the LPS are concerned with examining the proposed arrangements in comparison with potential alternative options; including

¹²¹ MCA Sch AA1 s6, s10.

¹²² 71 per cent of all DoLS applications in 2017-18 were from care homes (residential or nursing). NHS Digital (n 11).

¹²³ The Government described the scheme contained in the 2018 Bill as the "*Adjusted Liberty Protection Safeguards*" – Department of Health and Social Care, Mental Capacity (Amendment) Bill: Impact Assessment (2018) 1.

¹²⁴ MCA Sch AA1 s17(i), defined s3.

¹²⁵ See initial version of the Bill, dated July 2018 (n86).

¹²⁶ 'Mental Capacity (Amendment) Bill: Impact Assessment' (2018), (n 123) at [8.9].

¹²⁷ See n 90, n 93, n 94, n 95.

¹²⁸ 'Mental Capacity (Amendment) Bill: Impact Assessment' (2018), (n 123) at [8.6], [12.16].

¹²⁹ Hansard, HC Public Bill Committee (1st Sitting) col 67 (15 January 2019) (Alex Cunningham MP); Hansard, HC Series 6 (Report Stage) Vol 654 col 824 (12 February 2019) (Alex Cunningham MP).

¹³⁰ Mental Capacity (Amendment) Bill: Impact Assessment (2018) para 8.3, n 123.

¹³¹ W. Laing, *Adult specialist care: UK market report* (Second edition edn, Laing & Buisson 2016).

those in other settings than the care home. This is integral to the 'least restriction' principle contained in the MCA, DoLS and LPS, and is also a necessary ingredient of capacity assessments.¹³² Conversely, it is unlikely that the care home's own internal assessments—under the MCA—would explore alternative arrangements other than those that the care home could put in place. It is not the role of the care home manager to investigate other possible places where the person could receive care and support.

The care home arrangements were fiercely criticised in the Lords. The government responded by giving the responsible body discretion over whether they or the care home hold the reins in arranging the assessments.¹³³ Where the care home does, regulations will prohibit anybody with a 'prescribed connection' to the care home from conducting the key assessments. This is to protect against conflicts of interest.¹³⁴ Care homes will therefore be forbidden from relying upon their own internal assessments and will be required to source these from other professionals; yet it is unclear who will provide these assessments. This may be relatively straightforward when local authority and NHS professionals arrange care on behalf of these public bodies, however privately arranged care will not necessarily involve independent professional assessments under the MCA. This issue is revisited for the different assessments below.

D. Authorisation Conditions and Assessments

The DoLS have six qualifying requirements, assessed by the Best Interests Assessor (BIA) or the Mental Health Assessor (MHA). The government boasted of reducing this to three assessments under the LPS:¹³⁵ medical, mental capacity and 'necessary and proportionate'. In reality, responsible bodies will still need to be assured of similar criteria and make similar determination as under the DoLS.¹³⁶ What has changed is who can determine whether these are met.

E. Age

Although the MCA applies from age 16 upwards,¹³⁷ the DoLS only applied to people aged over 18.¹³⁸ However, following *Cheshire West*¹³⁹ potentially thousands of children and young people in the care of the state are considered to be deprived of their liberty.¹⁴⁰ At

¹³² A pre-requisite of a capacity assessment, see: *CC v KK and STCC* [2012] EWHC 2136 (COP).

¹³³ MCA Sched AA1 s17.

¹³⁴ MCA Sched AA s21(5) (for medical and mental capacity assessments) and s22(3) (for the necessary and proportionate determination).

¹³⁵ 'Equality Analysis: Liberty Protection Safeguards – Mental Capacity (Amendment) Bill' (n 103) [6].

¹³⁶ National DoLS Leads Group written evidence to the Public Bill Committee, at: <https://publications.parliament.uk/pa/cm201719/cmpublic/MentalCapacity/memo/MCAB02.pdf>.

¹³⁷ MCA s2(5).

¹³⁸ MCA Sched A1 s13.

¹³⁹ See *Cheshire West*, n 58, and n 69 for deprivation of liberty cases concerning people aged under 18.

¹⁴⁰ The Law Commission estimated this might affect 2,667 16- and 17-year olds who lacked capacity to consent to arrangements amounting to deprivation of liberty in special schools, residential care or hospitals. Response to request under the Freedom of Information Act 2000, 10 May 2019, n 13. See also: Children's Commissioner, *Who are they? Where are they? Children locked up (2019)* at: <https://www.childrenscommissioner.gov.uk/publication/who-are-they-where-are-they/>. In *Re D (A Child)* (n69) the Supreme Court confirmed that parents cannot consent to a deprivation of liberty on behalf of children.

present, these must be authorised by the courts. The Law Commission recommended that the LPS apply to 16- and 17-year olds.¹⁴¹ The government accepted this recommendation,¹⁴² and the LPS will apply from 16 upwards.¹⁴³ The care home arrangements, however, only apply from 18 upwards.¹⁴⁴

F. Mental Disorder

Article 5(1) ECHR permits detention only on certain limited grounds, including 'unsoundness of mind'.¹⁴⁵ This ground directly conflicts with article 14 CRPD,¹⁴⁶ which provides that 'the existence of a disability shall in no case justify a deprivation of liberty'.¹⁴⁷ The Law Commission concluded that the CRPD Committee's approach required 'a greater process of change over a much longer timescale',¹⁴⁸ prioritising (for now) compliance with the ECHR.

Article 5(1)(e) requires 'objective medical evidence' of a 'true mental disorder' of a 'kind or degree warranting compulsory confinement'.¹⁴⁹ The DoLS 'mental health' criterion employs the definition of 'mental disorder' established by the MHA—'any disorder or disability of the mind'¹⁵⁰—but with a qualification restricting the MHA's application to people with learning disabilities¹⁵¹ removed.

The Law Commissioners were concerned that this potentially excluded people with 'pure' brain disorders, such as a stroke.¹⁵² It is not obvious why this would not constitute a 'disorder or disability of the mind', but this may reflect a cultural reluctance within psychiatry to apply the MHA to these populations. To accommodate these cases, the Commission initially proposed use of the MCA's diagnostic threshold—'an impairment of, or a disturbance in the functioning of, the mind or brain'¹⁵³—but later concluded that this

¹⁴¹ Law Com 372 (n 71), Recommendation 5.

¹⁴² 'Final Government Response to the Law Commission's review of Deprivation of Liberty Safeguards and Mental Capacity', n 87, Recommendation 5.

¹⁴³ MCA Sched AA1 s2(2)(a).

¹⁴⁴ MCA Sched AA1 s3, s20(1)(a).

¹⁴⁵ Article 5(1)(e).

¹⁴⁶ P. Fennell and U. Khaliq, 'Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English law' (2011) 6 European Human Rights Law Review, 662-74; P. Bartlett, 'A mental disorder of a kind or degree warranting confinement: examining justifications for psychiatric detention' (2012) 16 (6) International Journal of Human Rights, 831-44. Although see also: E. Flynn, 'Disability, deprivation of liberty and human rights norms: Reconciling European and international approaches' (2016) 22 International Journal of Mental Health and Capacity Law, 75-101 <http://journals.northumbria.ac.uk/index.php/IJMHMCL/article/view/503/997>. Also considered in: *Rooman v Belgium* [2018] M.H.L.R. 250; BAILII 2019 ECHR 105 – and 'Modernising the Mental Health Act', n 17, Annex B.

¹⁴⁷ See also: Committee on the Rights of Persons with Disabilities, 'Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities' GAOR, 72nd session, Suppl no 55 Annex, 2017 (Adopted by the CRPD during its 14th session, 17 August-4 September 2015).

¹⁴⁸ Law Com CP 222, n 53, [3.22].

¹⁴⁹ *Winterwerp*, n 115, at [39].

¹⁵⁰ MHA s1(2).

¹⁵¹ MHA s(2A), as amended by MHA 2007. The term 'learning disability', rather than intellectual disability, is used in UK legislation and policy. Where referring to specific UK legislation or policy, the phrase 'learning disability' will accordingly be used.

¹⁵² Law Com CP 222, n 53 [6.8]-[6.9].

¹⁵³ MCA s2(1).

was too broad. Applying Goldilocks logic, they eventually recommended a test of 'unsoundness of mind' for its fit with article 5(1)(e).¹⁵⁴ Predictably this caused widespread offence, and the government amended the Bill so that the LPS now employs the same 'mental disorder' test as the DoLS.¹⁵⁵

The DoLS require the 'mental health' assessment to be conducted by the MHAr, who must be a registered medical professional with specialist qualifications and experience.¹⁵⁶ However the LPS do not replicate this role; there is limited specification of who can undertake the 'medical assessment' of whether a person has a mental disorder. The Law Commission noted 'encouraging developments' in Strasbourg suggesting 'general practitioners, psychologists and psychotherapists' could provide the necessary medical evidence¹⁵⁷, and the government repeated this in parliamentary debates.¹⁵⁸ Medical professional bodies were concerned that the 2019 amendments did not require those undertaking the 'medical assessment' to have medical qualifications.¹⁵⁹ The ECtHR has more recently indicated that in some circumstances psychiatric expertise is necessary.¹⁶⁰ Statutory 'requirements' for those undertaking LPS medical assessments has been deferred to regulations.¹⁶¹ Initial impact assessments indicate the government expects GP's to perform LPS medical assessments for free.¹⁶² However, there is no mandatory obligation on them to do so and charging regulations do not prohibit them from charging patients for this.¹⁶³

G. Mental Capacity

The DoLS require assessment of whether the person has the mental capacity to decide 'whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment.'¹⁶⁴ This assessment may be conducted either by the BIA or the MHAr. Of the six DoLS qualifying requirements, 'mental capacity' is the one that is most frequently found not to be met by DoLS assessors.¹⁶⁵

Under the LPS, the assessment of mental capacity no longer concerns accommodation but 'consent to the arrangements'.¹⁶⁶ Here, the tricky distinction between care and treatment and detention itself, which also figures under the DoLS, comes into sharp relief. Do the LPS require capacity assessors, reviewers, and the Court of Protection to only consider

¹⁵⁴ Law Com CP 222, n 53, [9.19].

¹⁵⁵ MCA Sch AA1 s13(b).

¹⁵⁶ The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 SI 2008/1858, Regulation 4.

¹⁵⁷ Law Com 372 (n 71), [9.60].

¹⁵⁸ Hansard, HC Public Bill Committee (3rd Sitting) col 99 (17 January 2019) (Caroline Dinenage MP).

¹⁵⁹ Written evidence submitted to the Public Bill Committee by the Royal College of Psychiatrists (RCPsych) (MCAB44) and the British Medical Association, at: <https://services.parliament.uk/Bills/2017-19/mentalcapacityamendment/committees/houseofcommonspublicbillcommitteethementalcapacityamendmentbillh201719.html>.

¹⁶⁰ *Ilseher v Germany* [2019] M.H.L.R. 278; BAILII 2018 (Grand Chamber) ECHR 991, [130].

¹⁶¹ MCA Sched AA1 s21(3).

¹⁶² 'Impact Assessment: Mental Capacity (Amendment) Bill' (2019) (n 5) [8.6].

¹⁶³ D. Lock QC, 'Chapter 8: When can fees be charged to a patient by a GP Practice?' *GP Law*, at: <http://www.gplaw.co.uk/chapter-8-when-can-fees-be-charged-to-a-patient-by-a-gp-practice#Chapter808>.

¹⁶⁴ MCA Sched A1, s15.

¹⁶⁵ NHS Digital (2019), n 10, Annex A Table 6.

¹⁶⁶ MCA Sched AA1 s13(a).

whether a person can make decisions about the 'arrangements' to facilitate care and treatment, not the underlying care and treatment decision itself? For example, should LPS capacity assessors simply accept—without question—underlying assessments that a person lacks capacity to consent (or refuse) a specific treatment, or to restrict contact with loved ones, or even where to live? If a regime of supervision and control is imposed to prevent sexual activity on the basis that a person lacks the capacity to consent to sex,¹⁶⁷ must the LPS capacity assessment start from the premise that this assessment is correct and merely consider the arrangements to secure this protection? The Code may offer guidance here, but the issue forces a reckoning with the underlying question of what the LPS are safeguards against.

Regulations will 'make provision' for who can provide a capacity assessment under the LPS.¹⁶⁸ For care home arrangements, assessments cannot be undertaken by anyone with a 'prescribed connection' to the care home.¹⁶⁹ Care homes will therefore need to source capacity assessments from third parties. Where care is publicly funded or arranged, public bodies should in theory have undertaken capacity assessments for the care and treatment itself. For private self-funders, it is less likely that independent professionals will have assessed a person's capacity to consent to care arrangements, as local authority social workers or NHS professionals will be less likely to have arranged or commissioned the care. The government appears to believe that GPs will also conduct LPS capacity assessments for free,¹⁷⁰ yet they play little role in most decisions concerning residential care. This promises to be a major practical sticking point for the LPS unless resolved.

Although regulations specify who can conduct capacity and medical assessments, the responsible body or care home manager must 'determine' whether these authorisation conditions are met.¹⁷¹ The 'determination' may be based on a previous LPS assessment, or an assessment for another purpose, provided it appears 'that it is reasonable to rely on the assessment',¹⁷² having regard to: the length of time since it was carried out, its purpose, and whether there has been a change in the person's condition.¹⁷³

IV. FROM 'BEST INTERESTS' TO 'NECESSARY AND PROPORTIONATE'

Detention under article 5(1)(e) ECHR must be necessary and proportionate with regard to the risk of harm to the person or to others.¹⁷⁴ Additionally, and so far as is possible, protective measures should reflect 'the wishes of individuals capable of expressing their will'.¹⁷⁵ These elements of the lawfulness of deprivation of liberty are dealt with under the LPS's new 'necessary and proportionate' test, which replaces the DoLS 'best interests' assessment.

¹⁶⁷ *IM v LM* [2014] EWCA Civ 37, [1]].

¹⁶⁸ MCA Sched AA1 s21(4).

¹⁶⁹ MCA Sched AA1 s21(5).

¹⁷⁰ 'Impact Assessment: Mental Capacity (Amendment) Bill' (2019) (n 5) [8.6].

¹⁷¹ MCA Sched AA1 s21(2).

¹⁷² MCA Sched AA1 s21(8).

¹⁷³ MCA Sched AA1 s21(9).

¹⁷⁴ *Litwa v Poland* (2001) 33 E.H.R.R. 53 [78]; [2000] M.H.L.R. 226. *Stanev v Bulgaria*, n 15, [143]; *Saadi v UK* (2008) 47 E.H.R.R. 17 at [54].

¹⁷⁵ *Mihailovs v Latvia*, n 60, [145].

The DoLS' best interests assessment is regarded by many as the 'cornerstone' of the authorisation process.¹⁷⁶ It must be conducted by the BIA, typically a social worker, who must have specialist skills, training and experience¹⁷⁷, and be independent of the person's care and treatment.¹⁷⁸ The BIA must determine whether it is in the person's 'best interests' to be a 'detained resident', whether it is necessary for them to be detained 'in order to prevent harm to the relevant person' and whether this is a proportionate response to the likelihood and seriousness of that person suffering harm if they were not detained.¹⁷⁹ In practice, it is extremely rare for the 'best interests' requirement of the DoLS to be found not to be met.¹⁸⁰ However, it is possible that the process of assessment, and the potential for BIA's to recommend 'conditions' for authorisation, may still lead to reduced restrictions or substantive changes to care arrangements. No data are collected on this, however.

BIAs told the Law Commission that the test could be difficult to apply in practice. Unlike the MHA, risk of harm to others is not a potential ground for detention under the DoLS. However, at the fringes of the DoLS were cases like *P v A Local Authority*¹⁸¹, where the real reason for the restrictions were less to prevent harm to the person than to others.¹⁸² This included cases (like P's) of young men with intellectual disabilities who were sexually attracted to children, as well as people who sometimes acted aggressively towards other residents or loved ones, or people who might otherwise be detained under the MHA. It was sometimes argued that it is in a person's best interests to prevent them from harming others, for example if they themselves would have wished to be prevented from hurting other people, or to prevent serious consequential risks such as a community backlash, imprisonment or detention in hospital under the MHA.¹⁸³ In *P v A Local Authority*, the authorisation was discharged by the Court of Protection as not being necessary and proportionate in relation to the risk to P himself. Reportedly, P subsequently offended and was imprisoned.¹⁸⁴ The Commission's suggestion of including a new ground of risk of harm to others within the best interests test¹⁸⁵ received a mixed response at consultation: some viewed this as avoiding intellectual dishonesty or more restrictive measures, others were nervous about the MCA straying into the traditional public protection terrain of the MHA. Some asked 'how far can this be taken before it goes beyond the remit of the Mental Capacity Act'?¹⁸⁶

The Commission also heard that BIAs found it hard to describe some care arrangements as being in the 'best interests' of a person, when in reality they were the only available

¹⁷⁶ Law Com 372 (n71) 75.

¹⁷⁷ The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 SI 2008/1858, regulation 5.

¹⁷⁸ Ministry of Justice, Mental Capacity Act 2005: Deprivation of Liberty Safeguards Code of Practice (Lord Chancellor's Office, 2008), [4.13], see also [4.66].

¹⁷⁹ MCA Sched A1, s16.

¹⁸⁰ NHS Digital (2019), n 12, Annex A, Table 6.

¹⁸¹ *P v A Local Authority* [2015] EWCOP 89.

¹⁸² See also: *Birmingham City Council v SR* [2019] EWCOP 28; *Y County Council v ZZ* [2012] EWCOP B34; *Re (N) (Deprivation of Liberty)* [2016] EWCOP 47.

¹⁸³ *Ibid*, and Law Com CP 222, n 53, [7.42].

¹⁸⁴ Hansard, HL Series 5 (Committee Stage 1st Sitting) Vol 792 col 1851 (5 September 2018) (The Baroness Ilora Finlay).

¹⁸⁵ Law Com CP 222, n53, Provisional proposal 7-10.

¹⁸⁶ Law Commission, 'Mental Capacity and Deprivation of Liberty - Consultation Analysis' (2017) [6.69] – [6.80], at: <http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/>.

option.¹⁸⁷ The best interests test, the Commission concluded, added 'nothing' to the assessment in the 'vast majority of cases',¹⁸⁸ but added 'complications'¹⁸⁹ in cases where the real concern was harm to others. They reached a radical conclusion: abolish the DoLS best interests requirement altogether, and replace it with a new test of whether the deprivation of liberty was necessary and proportionate with regard to either the risk of harm to the person *or to others*.¹⁹⁰ This test reflected the position under the ECHR¹⁹¹ and could accommodate cases like P's.¹⁹²

The Commission envisioned the MCA's best interests principle still playing a role in 'formulating the arrangements as a whole', strengthened by their wider proposed reforms to the MCA.¹⁹³ Yet they – and later the independent review of the MHA – acknowledged that the MCA's 'best interests' principle sits uneasily alongside public protection.¹⁹⁴ It was unclear whether the Commission intended that the LPS would empower responsible bodies to authorise arrangements that could potentially be said *not* to be in the person's best interests, extending powers of detention under the LPS beyond the traditional remit of the MCA, and bringing the MCA's detention framework into conflict with its main statutory principles.

The initial version of the government's Bill did not specify what detention must be 'necessary and proportionate' in relation to, as the MHA review was simultaneously considering the matter.¹⁹⁵ The government subsequently confirmed the LPS would include risk of harm to others,¹⁹⁶ but this would only be spelled out in the Code of Practice.¹⁹⁷ However there was no discussion of this issue in any of the Bill's supporting materials, so it was unclear how the new test would sit alongside the wider provisions of the MCA, or how open ended it might be. The Minister appeared to believe (incorrectly) that this mirrored the existing position under the DoLS.¹⁹⁸

Significant potential dilemmas arise in extending this ground of detention to include risk of harm to others. It would introduce a new public protection ethos within the MCA that is alien to its foundational principles. It would create new powers to detain on public protection grounds with very weak safeguards, and no consideration has been given to whether this might be used for new and unintended populations. It would, paradoxically, give public bodies administrative powers of detention on public protection grounds that

¹⁸⁷ Law Com 372 (n 71) at [9.25].

¹⁸⁸ Ibid, at [9.27].

¹⁸⁹ Ibid, at [9.28], [9.29].

¹⁹⁰ Ibid, at [9.30].

¹⁹¹ *Litwa v Poland*, n 174, at [78]; *Stanev v Bulgaria*, n 15, at [143]; *Saadi v UK*, n 174, at [54].

¹⁹² The case of *P v A Local Authority* was not discussed by the Commission, most likely because it was not reported publicly or placed on BAILII until 2019.

¹⁹³ Law Commission No 372 (n 71), at [9.31].

¹⁹⁴ Ibid, at [9.35]; 'Modernising the Mental Health Act', n 17, at [217].

¹⁹⁵ 'Annex A: Law Commission recommendations and Government Responses', n 87. Response to Recommendation 10.

¹⁹⁶ Hansard, HL Series 5 (Committee 2nd Sitting) Vol 793 col 384 (15 October 2018) (The Baroness Stedman Scott OBE – Government Spokesperson for the Lords, in response to a direct question from The Baroness Barker).

¹⁹⁷ Hansard, HL Series 5 (Report Stage 1st Sitting) Vol 794 col 285 (21 November 2018) (The Lord O'Shaughnessy).

¹⁹⁸ Hansard, HL Series 5 (Committee Stage 3rd Sitting) Vol 793 col 710 (22 October 2018) (The Lord O'Shaughnessy).

cannot be exercised by the Court of Protection itself. And there is a risk of highly complex interactions with the rest of the MCA when detention could be authorised under the LPS but cannot be justified on best interests grounds. The Lords voted to restrict the necessary and proportionate test to risk of harm to the person themselves,¹⁹⁹ and the government did not seek to reverse this. Consequently, 'risk of harm to others' is not grounds for detention under the LPS.²⁰⁰ Shortly afterwards the MHA review recommended including a ground of harm to others to enable the LPS to authorise inpatient detention in some circumstances where the MHA currently has to be used.²⁰¹ This issue may be revisited in a future mental health bill.

Those making necessary and proportionate 'determinations' must have regard 'to the cared-for person's wishes and feelings in relation to the arrangements'.²⁰² Although the DoLS' best interests test also required this²⁰³, wishes and feelings – and the need for strong justification to override these – assume greater visibility in the LPS. This is arguably one benefit of removing the 'best interests' test, and may be an incremental step towards the emphasis on the 'will and preferences' of the person required by the CRPD.²⁰⁴ However the presence of LPS criteria linked to disability will continue to remain an obstacle for CRPD compliance.

Once again, questions arise over how far consideration of underlying care and treatment decisions bleed into determinations of whether the arrangements are necessary and proportionate. For example, should those making the determination consider whether restrictions on contact with named persons, or finely balanced or contested medical treatments, are themselves necessary and proportionate? The ECtHR has recently clarified that article 5(1)(e) imposes an obligation to ensure 'appropriate and individualised therapy, based on the specific features of the compulsory confinement'. The court did not analyse the specific *content* of treatment, but sought to confirm that 'an individualised programme' was in place.²⁰⁵ LPS assessors will therefore need to make *some* enquiries into the 'therapeutic' purpose of detention. Notably, the government also intended the LPS to protect article 8 rights,²⁰⁶ implying some consideration of underlying care and treatment decisions.

Regulations will specify who may undertake the 'necessary and proportionate' determination. If the arrangements are 'care home arrangements' they may not have a 'prescribed connection' to the care home.²⁰⁷ There is no provision for use of prior or equivalent assessments for the necessary and proportionate determination, implying it must be carried out afresh for each authorisation. Unlike the capacity and medical assessments, which putatively impose no additional costs, the necessary and proportionate

¹⁹⁹ Hansard, HL Series 5 (n 197) col 286 (Division 1, called by The Baroness Barker).

²⁰⁰ MCA Sched AA1 s13(c).

²⁰¹ 'Modernising the Mental Health Act', n 17. 125.

²⁰² MCA Sched A1 s22(2).

²⁰³ MCA s4(6).

²⁰⁴ On which see: E. Jackson, n 79; L. Series, n 79; A. Ruck Keene and C. Auckland, 'More presumptions please? Wishes, feelings and best interests decision-making' (2015) 5 (3) Elder Law Journal 3, 293.

²⁰⁵ *Rooman v Belgium*, n146, at [205], [209].

²⁰⁶ 'Impact Assessment: Mental Capacity (Amendment) Bill' (2018) (n 123) 1, 9, [9.5], [16.8]; 'Impact Assessment: Mental Capacity (Amendment) Bill' (2019) (n 5) 1, [9.3], [16.8].

²⁰⁷ MCA Sched A1 s22(1) and 22(3).

assessment has been costed by the government (at £145.28).²⁰⁸ The expectation is that the responsible body will build this determination into care planning, with additional resources provided for responsible bodies to undertake the determination for those with privately arranged care.²⁰⁹

The DoLS required at least two assessors (BIA and MHA), one of whom must be independent of the person's care (the BIA), to conduct the relevant assessments. The Law Commission had proposed two assessors for the three core LPS assessments.²¹⁰ The 2019 amendments do not stipulate this; it is to be hoped that the new LPS Code will impose more demanding guidelines.

A. Consultation

The government asserted, somewhat misleadingly, that the LPS established a 'new' and stronger duty to consult with the cared-for person and their family²¹¹, in order to ascertain the 'wishes or feelings' of the person.²¹² The main difference is that the LPS consultation duty is explicit and contained within Schedule AA1, whereas the DoLS consultation duty was implicit, resting on the MCA's best interests' duty to consult others involved in the person's care or interested in their welfare about the person's wishes and feelings. Unlike the LPS, the best interests consultation duty also encompassed the person's values and beliefs,²¹³ and a more demanding duty to 'permit and encourage' the person to participate in decision making as 'fully as possible'; these provisions are not replicated in the LPS.²¹⁴ The LPS duty initially (inadvertently) excluded the cared-for person themselves from the list of persons to be consulted,²¹⁵ but this was rectified during the passage of the Bill.²¹⁶

The LPS consultation duty is vital for identifying potential objections, which trigger other key safeguards discussed below. The duty falls on the responsible body or – under the care home arrangements – the care home manager.²¹⁷ No 'prescribed connection' regulations apply to consultation, meaning this pivotal role may be undertaken by a person with a potential financial conflict of interest. There are risks that people may not feel comfortable expressing objections to those directly responsible for their care, or that potential signs of objection may be missed, dismissed or explained away. Meanwhile the person making the necessary and proportionate determination is under no statutory duty to consult the person directly,²¹⁸ and will therefore rely upon reports of their views by those carrying out the consultation. The capacity assessment offers a potential safeguard against

²⁰⁸ 'Impact Assessment: Mental Capacity (Amendment) Bill' (2019) (n 5) at [12.13].

²⁰⁹ Ibid, at [8.7], [12.13] and [12.32].

²¹⁰ Law Com 372 (n 71), Recommendation 13.

²¹¹ e.g. 'Mental Capacity (Amendment) Bill: Impact Assessment' (2018) (n 123) at [9.3]; 'Equality Analysis: Liberty Protection Safeguards – Mental Capacity (Amendment) Bill' (n 103) p 6; Hansard, HL Series col 1875 n 184 (The Lord O'Shaughnessy); Hansard, HC Series 6 (Ping Pong) Vol 657 col 972 (2 April 2019) (Jim Shannon MP).

²¹² MCA Sched AA1 s23(3).

²¹³ MCA s4(6)-(7).

²¹⁴ MCA s4(4).

²¹⁵ Law Com 372 (n71) Draft Sched AA1 s22(1).

²¹⁶ MCA Sch AA1 s23(2)(a).

²¹⁷ MCA Sch AA1 s23(1).

²¹⁸ However, the impact assessment does indirectly imply that they will 'visit' the person: 'Impact Assessment: Mental Capacity (Amendment) Bill' (2019), n 5, at [12.32].

distortion or misrepresentation of the person's views here, provided it properly documents any potential objections, since it *cannot* be undertaken by the care home.

B. 'No Refusals'?

The MCA enables a person with capacity to nominate their own preferred substitute decision maker in a Lasting Power of Attorney (LPA).²¹⁹ The Court of Protection may also appoint a deputy to make specified decisions on the person's behalf,²²⁰ and the person may themselves refuse specific medical treatments in advance.²²¹ The DoLS 'no refusals' requirement prohibited authorisations overriding a valid refusal of care and treatment by any attorney, deputy or the person themselves.²²² In effect, therefore, the DoLS do not empower supervisory bodies to 'trump' care and treatment decisions made by the person themselves, those they have selected to make decisions for them, or decision makers appointed by the court.

The Commission recommended a similar provision for the LPS,²²³ however it does not feature in the 2019 amendments. The government's rationale was that 'It is already the case that a best interest decision could not be taken which conflicted with a valid decision by an attorney/deputy.'²²⁴ The Bill does not alter this.²²⁵ Yet strictly speaking, there could be a valid objection to the *arrangements* authorised by the LPS but not the underlying care and treatment decisions.²²⁶ Had the LPS included a 'risk of harm to others' ground, this too could have circumvented objections insofar as it created scope for detention that is not justified on best interests grounds. Objections by attorneys or deputies and advance refusals may be considered under the necessary and proportionate determination, but the LPS offer no cast iron guarantee that they will be determinative.

The Law Society observed that the LPS could also be used to trump the objections of parents of 16 and 17 year olds without a court order.²²⁷ This seems to be confirmed by the Law Commission when they observe that parents would have a right to bring proceedings in the Court of Protection if they objected.²²⁸

There is therefore scope for highly complex litigation about the relative status of an LPS authorisation, the limits of parental authority, and other mechanisms for decision making under the MCA.

²¹⁹ MCA ss 9-14.

²²⁰ MCA s 16(2)(b).

²²¹ MCA s 24-26.

²²² Provided for by MCA ss22-25.

²²³ Law Com 372 (n 71) at [10.8]-[10.18]; Draft Schedule AA1, s15.

²²⁴ This is provided for by MCA s6(6), where a decision is made relying on the 'general defence'.

²²⁵ 'Annex A: Law Commission recommendations and Government Responses', n 87.

²²⁶ As noted by A. Ruck Keene, '*Mental Capacity (Amendment) Bill – highlights from final day of Lords Committee stage*' (Mental Capacity Law and Policy) 23 October 2018, at: http://www.mentalcapacitylawandpolicy.org.uk/mental-capacity-amendment-bill-highlights-from-final-day-of-lords-committee-stage/#_ftnref1.

²²⁷ See Law Society, n 92.

²²⁸ Law Com 372 (n 71) at [7.37].

V. INTERFACE WITH THE MENTAL HEALTH ACT 1983

The interface between the DoLS and the MHA is notorious for its complexity.²²⁹ It is governed by a separate schedule²³⁰ and an 'eligibility assessment' undertaken by a BIA or MHAr with further specialist qualifications.²³¹ In summary:

1 DoLS can authorise detention outside of hospital provided this does not conflict with any requirements imposed under a community MHA regime, such as guardianship, supervised community treatment or conditional discharge by a tribunal.

2 DoLS may authorise inpatient treatment for a *physical* disorder.

3 If the detention is to secure inpatient treatment for mental disorder²³² and the patient is 'within scope' of the MHA (that is, an application for detention could be made under s2 or s3 MHA) then patient is *ineligible* for the DoLS if they are objecting.²³³

4 Patients within scope of the MHA who are not objecting may be detained under either the MHA or the DoLS.²³⁴

5 Hospital inpatients may not fall 'within scope' of the MHA if they have recently been discharged by a tribunal²³⁵ or have learning disabilities²³⁶, in which case they may potentially be eligible for DoLS even if they are objecting.

The complexity of the two interlocking regimes can make it difficult for patients themselves to understand and exercise their rights, especially if subject to both simultaneously.²³⁷ The Law Commission heard reports of 'stand offs' between professionals arguing over which regime should be used.²³⁸

The issues at stake in this interface include the stigma and paternalistic culture associated with the MHA²³⁹ (although it is unclear whether same might also be said of DoLS and LPS) and the more rigorous procedural safeguards under the MHA. These include more initial assessments, powers of discharge for relatives, automatic referrals to the tribunal, safeguards governing treatment without consent and non-means tested aftercare. Their criteria for detention also differ: the MHA permits detention of those considered to have 'capacity' and also permits detention on grounds of risk to others, unlike the DoLS (and LPS).

²²⁹ E.g. Mental Capacity Act 2005: post-legislative scrutiny, n 36, at [271].

²³⁰ MCA Sched 1A.

²³¹ If undertaken by the MHAr, they must be an approved doctor under s12 MHA; if undertaken by the BIA, they must be qualified as an Approved Mental Health Professional.

²³² *GJ v The Foundation Trust & Anor* [2009] EWHC 2972 (Fam); [2010] M.H.L.R. 13.

²³³ MCA Schedule 1A s2 'Case E'.

²³⁴ *AM v South London & Maudsley NHS Foundation Trust and The Secretary of State for Health* [2013] UKUT 0365 (AAC); [2014] M.H.L.R. 181

²³⁵ R. Jones and E. Piffaretti, *Mental Capacity Act Manual* (8th edn, Sweet & Maxwell 2018) 354, citing *R. v East London and The City Mental Health Trust Ex P. Brandenburg* [2004] 2 A.C. 280; [2003] UKHL 58; [2004] M.H.L.R. 44.

²³⁶ By way of MHA s1(2A). *GJ v The Foundation Trust & Anor* n 232 at [29].

²³⁷ E.g. *C v Blackburn and Darwen Borough Council*, n 36; *KD v A Borough Council* [2015] UKUT 0251 (ACC); [2015] M.H.L.R. 358. *NM v Kent County Council* [2015] UKUT 125 (ACC); [2015] M.H.L.R. 343.

²³⁸ Law Com 372, n 71, at [13.11].

²³⁹ *Ibid*, at [13.16].

The Law Commission was troubled by the absence of a 'clear or meaningful test' for determining which scheme to use.²⁴⁰ One solution – favoured by the Commission and many consultees, but beyond its remit – was to 'fuse' the MCA and the MHA together, as Northern Ireland has.²⁴¹ Ultimately, the Commissioners were persuaded that retaining parallel legal regimes led to significant confusion and uncertainty in practice, and recommended that *only* the MHA should be available for detention on grounds of mental disorder (unless a patient had a learning disability).²⁴²

Following a 2017 election campaign pledge by Theresa May to address rising rates of detention under the MHA,²⁴³ an independent review of the Act had been established. Its recommendation was at odds with the Law Commission's: the DoLS/LPS should be retained for mental health detention, but discretion to use either regime should be eliminated by specifying that *only* the DoLS/LPS could be used in non-objecting cases.²⁴⁴ This would assist with the policy goal of reducing MHA detentions, but the same patients, subject to the same treatment and regimes, could instead be detained under the MCA, only with weaker procedural safeguards.

The interface rules between the DoLS and MHA are therefore more or less reproduced in the LPS at present,²⁴⁵ but may be revisited in the future. Responsible bodies (and care home managers) will therefore still be tasked with navigating this complex interface in ensuring the proposed arrangements are not excluded 'mental health arrangements' before they can be authorised.²⁴⁶ All that has changed is that this is no longer framed as a distinct 'assessment', and there are no statutory requirements for the qualifications or experience of those navigating this legal labyrinth.

A. Pre-Authorisation Review

The LPS aim to address the volume problem following *Cheshire West* by building the core assessments into existing care planning processes. It is hoped this 'streamlining' will lead to earlier and better consideration of the MCA and principles of necessity and proportionality during care and treatment decision making, *before* decisions are implemented.²⁴⁷ The cost of this streamlined approach, however, is reduced independent scrutiny by assessors who are not involved in care and treatment decisions. This independent safeguard against 'misjudgments and professional lapses' was a driving

²⁴⁰ Law Com CP 222, n 53, at [10.20].

²⁴¹ Mental Capacity Act (Northern Ireland) 2016 SI 2016/18.

²⁴² Law Com 372, n 71, recommendation 37.

²⁴³ M. Savage, 'Theresa May pledges mental health revolution will reduce detentions' (The Guardian 7 May 2017) at: <https://www.theguardian.com/politics/2017/may/07/theresa-may-pledges-mental-health-revolution-will-reduce-detentions>.

²⁴⁴ 'Modernising the Mental Health Act', n 17, Recommendation 41.

²⁴⁵ MCA Sched AA1 Part 7, 'Excluded Arrangements: Mental Health'. Note that an LPS authorisation can now sit alongside a MHA detention, to cater for the simultaneous delivery of physical healthcare under mental health detention, a gap identified in *A NHS Trust v Dr. A* [2013] EWHC 2442 (COP); [2014] 2 W.L.R. 607.

²⁴⁶ MCA Sched AA1 s2(c) states that 'This Schedule' does not apply to arrangements excluded by Part 7 ('Excluded arrangements: Mental Health'). When authorising the arrangements the responsible body (s18(a)) or the care home manager (s19(b)(i)) must be satisfied that the schedule 'applies to the arrangements'.

²⁴⁷ Law Com No 372, n71, at [5.31].

motivation behind both *HL v UK*²⁴⁸ and *Cheshire West*.²⁴⁹ Where the same professionals are involved in planning care and treatment and in authorising detention, the ECHR requires 'guarantees of independence' and counterbalancing procedures.²⁵⁰

Under the LPS this independent element is provided through a pre-authorisation review by the responsible body.²⁵¹ This must be carried out by somebody who is not involved in the 'day-to-day care' of the person or providing any treatment to them, and without any 'prescribed connection' to the care home.²⁵² There is no statutory provision for regulations stipulating qualifications or experiences, but some guidance may be provided in the Code. The reviewer is *personally*²⁵³ responsible for determining 'whether it is reasonable for the responsible body to conclude that the authorisation conditions are met' based on 'the information on which the responsible body relies'.²⁵⁴ The Law Commission anticipated that reviewers would not make additional enquiries or commission fresh assessments,²⁵⁵ but there is no statutory bar to them doing so. It is debatable how effective a safeguard this desktop review will prove to be where the information itself is of dubious quality or inaccurate. Some reviewers may adopt a muscular approach, refusing to authorise on the basis of visibly poor-quality assessments. Much will depend on the skills and experience of the reviewer, and the culture and resources of the institution.

B. Approved Mental Capacity Professionals

The Law Commission recognised that the role of BIAs was particularly important under the DoLS. They proposed a revised role as Approved Mental Capacity Professionals (AMCPs), central to the authorisation of arrangements amounting to deprivation of liberty. Following *Cheshire West* there are simply not enough BIAs to undertake assessments for all DoLS applications (one cause of supervisory body backlogs),²⁵⁶ and the Commission felt it was not 'proportionate or affordable' for AMCPs to be involved in every case under the LPS.²⁵⁷ They identified cases where the arrangements were 'contrary to the person's wishes' as most in need of oversight.²⁵⁸ Accordingly, wherever 'there is reason to believe' the cared-for person does not wish to reside in a particular place, or to receive care or treatment there, the case must be referred by independent reviewers to AMCPs.²⁵⁹

The Commission also recognised that other situations could require oversight, giving as examples cases where the person's wishes were unclear, the restrictions were 'particularly intensive or intrusive' or where those close to the person were objecting.²⁶⁰ Initially the government did not include the Commission's proposed discretionary power to refer cases

²⁴⁸ *HL v UK*, n 27, at [121].

²⁴⁹ *Cheshire West*, n58, at [1], [9], [32] and [57].

²⁵⁰ *IN v Ukraine* (App 28472/08); [2019] M.H.L.R. 124; BAILII [2016] ECHR 565, at [81].

²⁵¹ MCA Sched AA1 s24.

²⁵² MCA Sched AA1 s21(1).

²⁵³ Law Com No 372 (n 71) at [10.25].

²⁵⁴ MCA Sched AA1 s26.

²⁵⁵ Law Com No 372 (n 71) at [10.25].

²⁵⁶ Local Government Ombudsman, 'Investigation into a complaint against Staffordshire County Council' (reference number: 18 004 809) (2019).

²⁵⁷ Law Com No 372 (n71) at [10.32].

²⁵⁸ *Ibid*, at [10.35].

²⁵⁹ MCA Sched AA1 s24(2)(a)-(b).

²⁶⁰ Law Com No 372 (n 71) [10.43], Draft Bill Sched AA1 s23(3)(a).

to an AMCP in such scenarios, but following objections by stakeholders²⁶¹ it was reinserted.²⁶² Because of concerns about conflicts of interest for independent hospitals, these cases must also be referred to an AMCP.²⁶³ The government estimates that 25 per cent of all LPS applications will require review by an AMCP.²⁶⁴

AMCPs must 'review the information on which the responsible body relies' and 'determine whether the authorisation conditions are met'.²⁶⁵ Before making this determination the AMCP must – if it appears to them to be 'appropriate and practicable to do so' – meet with the cared-for person and consult those listed under the consultation duty.²⁶⁶ The government's anticipates only a 'small number' of cases where it is not appropriate for the AMCP to meet with the cared-for person.²⁶⁷

AMCPs have more flexible powers than BIAs. They have an open-ended power to 'take any other action' that appears to the AMCP to be appropriate and practicable.²⁶⁸ This could potentially include undertaking assessments themselves, taking steps to resolve disputes, or exploring less restrictive alternatives. The 2019 amendments do not include the Law Commission's recommendation that if AMCPs refuse to authorise arrangements they should give written reasons explaining why and describing necessary steps to obtain approval,²⁶⁹ but nothing prevents AMCPs from doing so. Whereas BIAs could only *recommend* that authorisation be subject to conditions,²⁷⁰ AMCPs potentially have greater control over the arrangements since the responsible body may *only* authorise them if the AMCP agrees the LPS conditions are met.²⁷¹

Despite the potential strengths of AMCPs, weaknesses remain. Roger Hargreaves, a retired social worker and DoLS policy lead, notes that the statutory restriction on 'day to day' involvement in care does not preclude some degree of involvement in underlying decisions²⁷², although the Code may go further. The biggest concern is whether referrals to AMCPs will be made where a person's wishes and feelings are unclear, contested, or potential objections are suppressed by medication, institutionalisation or fear of rocking the boat. Those detained for treatment for mental disorder in NHS hospitals are especially unlikely to be referred to an AMCP, because if they *are* regarded as objecting then they would generally be ineligible for the LPS.

²⁶¹ See for example the evidence to the Public Bill Committee of the National DoLS Leads, available at: <https://publications.parliament.uk/pa/cm201719/cmpublic/MentalCapacity/memo/MCAB02.pdf>.

²⁶² MCA Sched AA1 s24(2)(d).

²⁶³ MCA Sched AA1 s24(2)(c). This was inserted on Report following debates in the Public Bill Committee in the House of Commons.

²⁶⁴ Law Commission, 'Impact Assessment: Mental Capacity and Detention' (LAWCOM0055, 2017) 33.

²⁶⁵ MCA Sched AA1 s25(1).

²⁶⁶ MCA Sch AA1 s25(2).

²⁶⁷ 'Final Government Response to the Law Commission's review of Deprivation of Liberty Safeguards and Mental Capacity', n 87. Response to recommendation 20.

²⁶⁸ MCA Sched AA1 s25(2)(b).

²⁶⁹ Law Com No 372 (n71) at [10.51].

²⁷⁰ MCA Sched A1 s 52(2).

²⁷¹ MCA Sched AA1 s18(f) (for authorisation via responsible bodies), s19(e) (where authorised via the care home arrangements).

²⁷² Written evidence of Roger Hargreaves (MCAB04) to the Public Bill Committee, available at: <https://publications.parliament.uk/pa/cm201719/cmpublic/MentalCapacity/memo/MCAB04.htm>

C. The Duration of Authorisations

Article 5(1) requires reviews at 'reasonable intervals' to ensure the criteria for detention continue to be met.²⁷³ The supervisory body may specify a maximum duration of 12 months for a DoLS authorisation. Once expired, fresh authorisation must be sought, with the full complement of assessments and procedures. Consultees told the Law Commission this incurred 'significant costs' yet amounted to a 'rubber stamping exercise' when a person's condition was stable.²⁷⁴ The LPS introduce the option to 'renew' or vary an authorisation, indefinitely, without necessarily undertaking the full battery of assessments and determinations.

D. Renewals, Variations and Reviews

An initial LPS authorisation may last up to twelve months,²⁷⁵ then be renewed for a further twelve months and thereafter for periods of up to three years.²⁷⁶ Responsible bodies may renew the authorisation if they are satisfied that 'the authorisation conditions continue to be met', 'that it is unlikely that there will be any significant change in the cared-for person's condition during the renewal period which would affect whether those conditions are met', and they have carried out a fresh consultation under the consultation duty.²⁷⁷ Provided the responsible body is satisfied of the foregoing, they may also choose to renew on the basis of a written statement from the care home manager, where the care home carries out the consultation.²⁷⁸

The LPS also allow authorisations to be 'varied', provided the responsible body is satisfied both that a fresh consultation has been carried out by the responsible body or care home manager, and 'that it is reasonable to make the variation'.²⁷⁹

An authorisation ceases to have effect if the responsible body 'believes or ought reasonably to suspect that any of the authorisation conditions are not met'.²⁸⁰ Responsible bodies must specify a program of reviews of the authorisation,²⁸¹ and must additionally review an authorisation if it is varied, 'if a reasonable request is made by a person with an interest in the arrangements', if the cared-for person becomes subject to a regime of the MHA or receives inpatient treatment for mental disorder, or where the reviewer becomes aware of objections by the cared-for person but the original pre-authorisation review was not by an AMCP.²⁸² The review may be carried out by the responsible body, or by the care home manager.²⁸³

²⁷³ *Winterwerp*, n 115, at [55].

²⁷⁴ 'Mental Capacity and Deprivation of Liberty - Consultation Analysis', n 186, [11.30].

²⁷⁵ MCA Sched AA1 s29.

²⁷⁶ MCA Sched AA1 s32.

²⁷⁷ MCA Sched AA1 s33 and s34.

²⁷⁸ MCA Sched AA1 s33 and s35.

²⁷⁹ MCA Sched AA1 s37.

²⁸⁰ MCA Sched AA1 s29(4).

²⁸¹ MCA Sched AA1 s27(1)(b) and s38(2).

²⁸² MCA Sched AA1 s38(3).

²⁸³ MCA Sched AA1 s38(1).

There is no statutory requirement for fresh medical or capacity assessments, or 'necessary and proportionate' determinations for renewals, variations or reviews. This is potentially a matter of serious concern given that authorisation may be renewed indefinitely and variations to an authorisation may potentially involve significant changes. The Law Commission²⁸⁴ and the government²⁸⁵ anticipated that most reviews would require a fresh necessary and proportionate determination, and this may be recommended in the Code. Guidance will be needed on the point beyond which it is not 'reasonable' to deal with changes without a fresh authorisation, with the full battery of assessments and determinations.

The LPS renewal process is roughly analogous to the approach taken under the MHA. However, the timescales for renewals under the MHA are much shorter (initially after six months and thereafter every 12 months), and MHA renewals require a report by the responsible clinician to the hospital managers.²⁸⁶ Under the LPS, statutory requirements for independence (of reviewers) and regulations concerning qualifications or experience do not apply to renewals or reviews unless AMCPs carry them out. In the MHA context, further protection is offered by other available safeguards, not least automatic periodic reviews by a tribunal; equivalent safeguards are far weaker under the LPS. The 'adjusted' LPS therefore provide for indefinite detention with very limited independent oversight.

E. Interim Authorisations and Emergencies

The MCA only protects against liability for deprivation of liberty where a standard or urgent²⁸⁷ DoLS authorisation is in place, or where court authorisation is being sought or has been granted.²⁸⁸ This creates potential gaps in protection against liability for care and treatment providers. Providers waiting longer than two weeks for a standard authorisation (as most currently will) are in theory exposed to liability, and the MCA does not provide for deprivation of liberty in emergency situations where it is not feasible to make a DoLS or court application.²⁸⁹

The LPS offer interim protection against liability whilst the responsible body is carrying out functions under the LPS 'with a view to determining' whether to authorise the arrangements, or a care home has taken 'reasonable steps' to notify the responsible body of any such arrangements.²⁹⁰ There is also emergency protection against liability for those undertaking 'vital acts' to prevent 'a serious deterioration in P's condition', provided there is a reasonable belief that the person lacks capacity and it would not be 'reasonably practicable' to make an application for the person to be detained under the LPS or Part 2 of the MHA.²⁹¹

²⁸⁴ Law Commission impact assessment, n 261, 31.

²⁸⁵ 'Impact Assessment: Mental Capacity (Amendment) Bill' (2018), n 123, at [12.19]; 'Impact Assessment: Mental Capacity (Amendment) Bill' (2019), n 5, [12.31] – [12.32].

²⁸⁶ MHA s20.

²⁸⁷ Under the DoLS, managing authorities can issue an 'urgent authorisation' for up to two weeks whilst awaiting a standard authorisation from the supervisory body, MCA Sch A1 Part 5.

²⁸⁸ MCA s4A (prior to 2019 amendments).

²⁸⁹ A. Ruck Keene and others, 'Deprivation of liberty in the hospital setting' (39 Essex Chambers Guidance Note, 2018) at [45] – [50] at: <https://www.39essex.com/mental-capacity-guidance-note-deprivation-liberty-hospital-setting/>.

²⁹⁰ MCA s4B(7)(b).

²⁹¹ MCA s4B(2)-(6)(b).

The Law Commission recommended against imposing a time limit on interim authorisations lest responsible bodies aimed for a maximum time.²⁹² Opposition amendments to limit emergency provisions to 14 days were rejected by the government on the same grounds,²⁹³ but guidance will be provided in the Code.²⁹⁴ Of particular concern is the absence of any clear commitment to legal aid for challenges pending authorisation.²⁹⁵

F. Rights of Challenge

Article 5(4) rights to a court review of detention are a fundamental safeguard against arbitrary detention. Rights of challenge are especially important under article 5 when – as under DoLS, LPS and the MHA – detention is initiated without involving the courts.²⁹⁶ Under article 5(4) *everyone* who is deprived of their liberty is entitled ‘to take proceedings by which the lawfulness of his detention shall be decided speedily by a court’. This must be ‘accessible to the person’, and ‘practical and effective’.²⁹⁷ ‘Special procedural safeguards’ may be needed to ‘protect the interests’ of those who are ‘not fully capable of acting for themselves’.²⁹⁸

States have a margin of appreciation over how this is realised.²⁹⁹ The mechanism employed by the MHA is an automatic periodic referral to a tribunal,³⁰⁰ to counteract for what Gostin called ‘the burden of coming forward’ in initiating an appeal.³⁰¹ The Law Commission considered this³⁰² but it would have had tremendous resource implications because of the scale of detention under LPS.³⁰³

Alternatively, states might ‘empower or even require’ someone to act on the person’s behalf.³⁰⁴ Both DoLS and the LPS adopt this approach through complex provisions for representation and advocacy. However, this approach raises the risk that representatives may decline to act on the person’s behalf if they view the detention as in the person’s best interests or regard a challenge as futile. The ECtHR has held that rights of appeal must not

²⁹² Law Com No 372 (n 71), Recommendation 15.33.

²⁹³ Hansard, HC Public Bill Committee (6th Sitting) col 173-78, n 100 and see Division 22.

²⁹⁴ Hansard, HL Series 5 (Committee Stage 1st Sitting) col 1848, no 184.

²⁹⁵ V. Butler-Cole and A. Boukraa, ‘LPS–challenges and criticisms’ (39 Essex Chambers, 2019) <https://1f2ca7mxjow42e65q49871m1-wpengine.netdna-ssl.com/wp-content/uploads/2019/04/Liberty-Protection-Safeguards-the-new-law-Criticisms.pdf>.

²⁹⁶ *D.D. v Lithuania*, n 15, at [164]; *Kędzior v Poland*, n 60, at [76]; *Mihailovs v Latvia*, n 60, [155].

²⁹⁷ *MH v UK* (2014) 58 E.H.R.R. 35; [2014] M.H.L.R. 249; BAILII 2013 ECHR, at [75].

²⁹⁸ This principle was first established in *Winterwerp*, n 115, at [60], and is reiterated in most subsequent cases concerning rights of appeal against mental health detention.

²⁹⁹ *MH v UK*, n 297, at [75].

³⁰⁰ MHA s68.

³⁰¹ L. Gostin, *A Human Condition* (A MIND Special Report, 1975).

³⁰² Law Com CP 222, n53, Question 11-5

³⁰³ Law Commission, Impact Assessment: Mental Capacity and Detention (LAWCOM0044, 2015), see assumptions on page 30.

³⁰⁴ *MH v UK*, n 297.

depend on the goodwill or discretion of third parties³⁰⁵; there must be a clear *duty* to assist.³⁰⁶

A refusal to assist in bringing an appeal cannot be justified by prospects of success³⁰⁷ In *AJ v A Local Authority*³⁰⁸ the Court of Protection held that 'there is no place in Article 5(4) for a best interests decision about the exercise of that right since that would potentially prevent the involvement of the court'.³⁰⁹ If a detained person is unable to enlist assistance to appeal, then article 5(4) may be violated.³¹⁰ This approach mirrors the *Neary* dictum that a person is 'not only entitled but must be *enabled*' to appeal.³¹¹

G. Representation and Advocacy

Under both the DoLS and the LPS the primary responsibility for 'enabling' rights of challenge fall on informal representatives – RPRs under the DoLS and 'appropriate persons' under the LPS. These will generally be friends or relatives of the person. Difficulties arise if they are unwilling, unable or unclear about obligations to enable rights of challenge. Friends and relatives may also find the court appeal process daunting or bewildering – an octogenarian RPR described it as 'complex and harrowing'.³¹² Others, like Steven Neary's father, may be scared of rocking the boat when reliant on the responsible body to provide care or treatment. In *AJ* the Court of Protection held that RPRs must be both willing and able to assist the person in exercising rights of challenge.³¹³ Close relatives or friends who supported or helped set up the arrangements may therefore be inappropriate because of their clear conflict of interest in challenging them.³¹⁴ This is likely to be a particular concern for privately arranged care for many older people. Responsible bodies are obliged to monitor the RPR and terminate their appointment if they fail to fulfil this representation role.³¹⁵

The provisions for representation and advocacy under both the DoLS and LPS are extremely complex and are depicted in Fig 2 (for DoLS) and Fig 3 (for LPS). There are some important differences between the two schemes. The DoLS require that a person is represented by an RPR or an IMCA, or both, in all circumstances. The same cannot be said for the LPS: as Fig 3 shows, there are various circumstances where a detained person may have nobody representing them. The DoLS also guarantees to the detained person a freestanding unconditional right to request an IMCA, however under the LPS if the responsible body is satisfied there is an 'appropriate person' to represent the cared-for person, their right to

³⁰⁵ *Stanev v Bulgaria*, n 15, at [174]; *Lashin v Russia* (App 33117/02); [2014] M.H.L.R. 109; BAILII [2012] ECHR 63, at [121]; *DD v Lithuania*, n 15, at [166]; *Shtukaturv v Russia* (2012) 54 E.H.R.R. 27; [2008] M.H.L.R. 238; BAILII [2008] ECHR 223, at [124]; *Sýkora v The Czech Republic* (App 23419/07); [2013] M.H.L.R. 283; BAILII [2012] ECHR 1960, at [179]; *MH v UK*, n 297, at [92], [94].

³⁰⁶ *MH v UK*, n297, at [94]

³⁰⁷ *Winterwerp*, n 115, at [64]. See also: *Waite v UK* (2003) 36 E.H.R.R. 54; [2003] Prison L.R. 160; BAILII [2002] ECHR 804.

³⁰⁸ *AJ v A Local Authority* [2015] Fam. 291; [2015] EWCOP 5.

³⁰⁹ *Ibid*, at [88].

³¹⁰ *Storck v Germany* (2005) 43 EHRR 96, at [118]; [2005] M.H.L.R. 211. *MH v UK*, n 297, at [95].

³¹¹ *Neary*, n39, at [202].

³¹² 'Mental Capacity Act 2005: post-legislative scrutiny', n 36, at [287].

³¹³ *AJ*, n 308, at [80] – [86], [89].

³¹⁴ *Ibid*, at [137].

³¹⁵ *Ibid*, at [139].

request an IMCA in effect transfers to the appropriate person. Under the DoLS, the provisions for appointing an IMCA are based on situations where otherwise the person would be unrepresented³¹⁶, or where an (unpaid) RPR and the detained person are likely to, or already have, failed to exercise rights of challenge when it would be 'reasonable' to do so.³¹⁷ This means that under the DoLS if there is an indication that the person might wish to exercise rights of appeal and the RPR is not assisting them, the supervisory body must appoint an IMCA to assist them. However, under the LPS, duties to appoint an IMCA are based on capacity and best interests determinations,³¹⁸ creating a clear risk of concluding that it is not in a person's 'best interests' to be provided with advocacy support to exercise rights of challenge.

Under the DoLS, supervisory bodies 'must appoint' an IMCA where the relevant duties are engaged,³¹⁹ but under the LPS responsible bodies must only take 'reasonable steps' to do so. There are therefore numerous situations under the LPS where best interests decisions, a failure to appoint an IMCA, or a failure to ensure representatives are both willing and able to challenge the detention potentially stand between a person being *entitled* to appeal and their being *enabled* to do so.

The risk that a person will be unable to exercise rights of challenge under article 5(4) is, if anything, further increased under the LPS in comparison with the existing problems under the DoLS.

³¹⁶ MCA s39A and MCA s39C.

³¹⁷ MCA s39D.

³¹⁸ This is modelled on similar provisions under the Care Act 2014, which may be appropriate for enabling involvement in care planning but which are not necessarily apt for securing rights of challenge.

³¹⁹ MCA s39A-s39D.

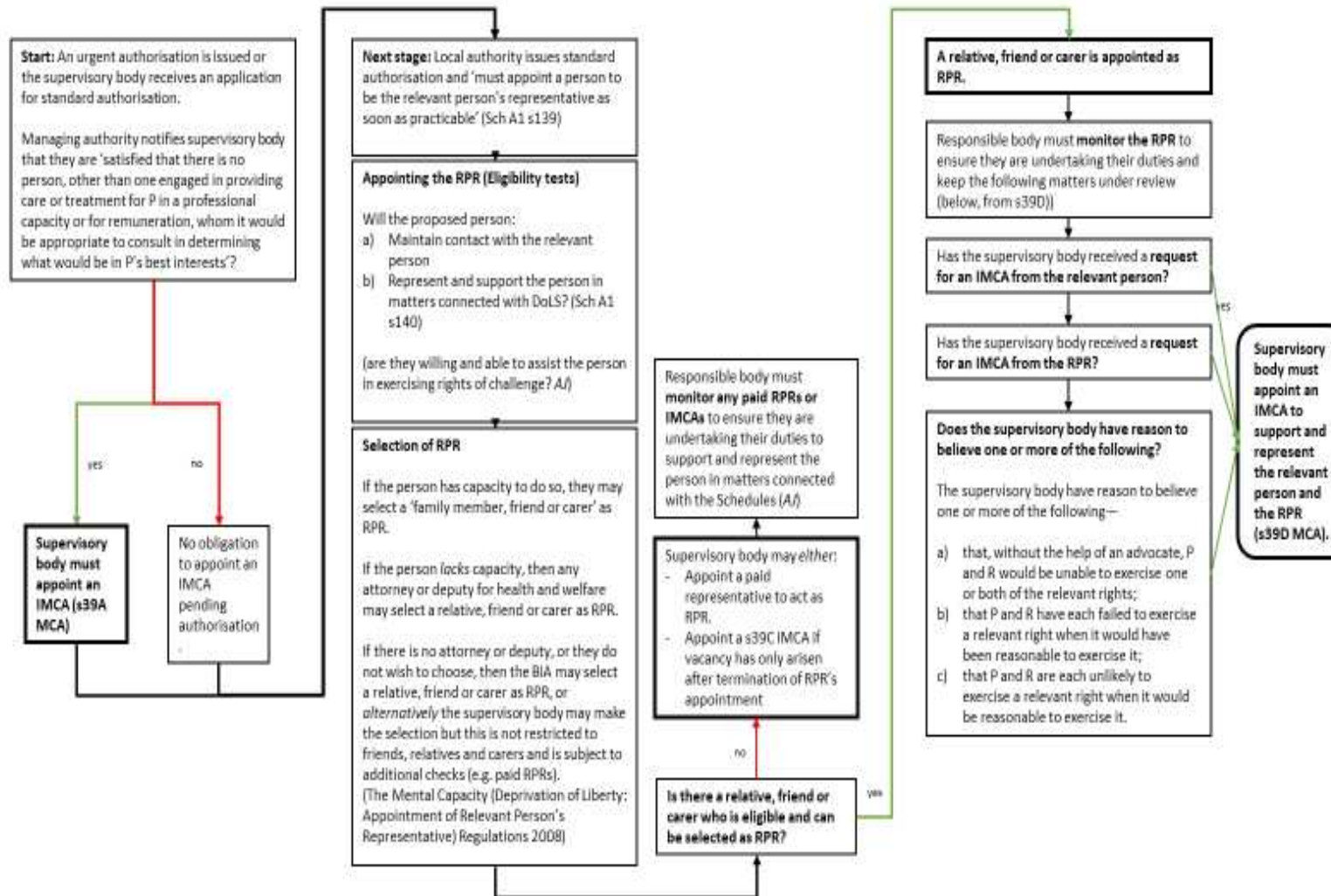


Figure 2 Schematic depiction of provision for advocacy and representation under the DoLS

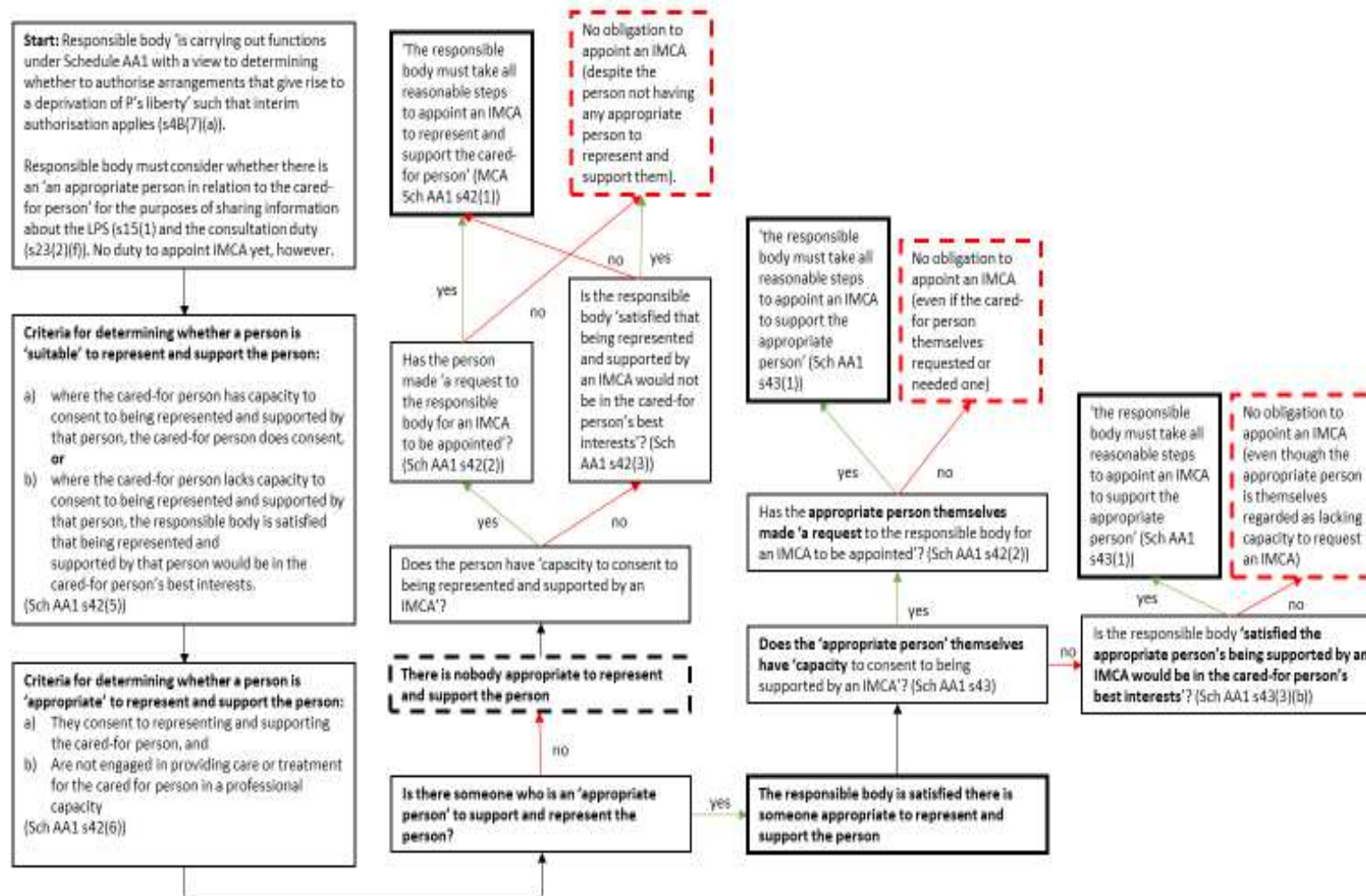


Figure 3 Schematic depiction of provisions for advocacy and representation under the LPS

Given the sheer complexity and gaps in both schemes it may be preferable to place the primary duty to enable rights of challenge on responsible bodies, instead of their serving as a 'fallback' where representatives have failed to do so. However, this was not considered by the Law Commission, and although a provision to this effect was inserted into the Bill in the Lords³²⁰ it was removed by a later government amendment. The government's approach was that detained persons and their relatives were of course 'entitled' to appeal but that recourse to courts should be avoided.³²¹ The question of whether a detained person would be *enabled* to appeal when they wished to do so was not addressed. The Law Commission had envisioned an automatic opt-out advocacy scheme, meaning the majority of people would receive expert assistance and advice on rights of challenge.³²² However, the government was concerned about the 'imposition' of advocacy and felt 'support from family and friends may be more appropriate and beneficial'.³²³ Thus the 2019 amendments reverted to more limited scheme of independent advocacy, prioritising the putative preferences of families over enabling rights of challenge.

H. Rights to Information

Rights of challenge can only operate effectively if people are informed of their rights.³²⁴ Thus Article 5(2) contains a duty to inform a person promptly and 'in a language which he understands' of the reasons why they have been deprived of their liberty.³²⁵ Detaining authorities must take 'reasonable steps' to impart this information³²⁶ – and where the person would not be able to understand it should be communicated to others able to represent their interests.³²⁷

The DoLS require the managing authority of the care home or hospital to inform the detained person about the authorisation and their rights,³²⁸ whilst the supervisory body must give copies of the authorisation documentation to those representing the detained person, and 'every interested person consulted by the best interests assessor'.³²⁹ The Law Commission did not discuss rights to information in their consultation and they did not appear initially in the 2018 Bill. This was raised as a concern by stakeholders and peers in the Lords. Bizarrely, the Minister at one point suggested that people could make subject access requests for this information under the GDPR,³³⁰ implying a fundamental lack of understanding of the nature of this safeguard.

³²⁰ This formed part of the 'rights to information' amendment inserted into the Lords. The relevant clause (s13(5) of the Bill as brought forward from the Lords) read 'The responsible body must ensure that cases are referred to court when the cared-for person's right to a court review is engaged.'

³²¹ Hansard, HL Series 5 col 371, n 196.

³²² Law Com No 372 (n 71) [12.40].

³²³ 'Mental Capacity and Deprivation of Liberty - Consultation Analysis', n186, [8.7].

³²⁴ *Van Der Leer v The Netherlands* [1990] 12 E.H.R.R. 567, at [27]; *X v United Kingdom* (1982) 4 E.H.R.R. 188; *LM v Slovenia* (App 32863/05); [2019] M.H.L.R. 67; BAILII [2014] ECHR 608, at [1452].

³²⁵ *Ibid.*

³²⁶ *ZH v Hungary* (App 28973/11); [2014] M.H.L.R. 1; BAILII [2012] ECHR 1891, at [41].

³²⁷ *Ibid.*; *LM v Slovenia* n 324; *X v UK* (App no 6998/75) [1980] ECHR Report of the Commission (Adopted on 16 July 1980), see also related proceedings before ECtHR (1982) 4 E.H.R.R. 188

³²⁸ MCA Sched A1 s 59.

³²⁹ MCA Sched A1 s57.

³³⁰ Hansard, HL Series 5 col 337 no 196 (The Lord O'Shaughnessy).

The Lords inserted an amendment containing rights to information into the Bill³³¹, which was accepted in principle but redrafted by the government in the Commons. The LPS now contain a three-stage information duty. Responsible bodies must publish general information about the authorisation process and people's rights under the LPS scheme, in formats that are 'accessible to, and appropriate to the needs of, cared-for persons and appropriate persons'.³³² Once arrangements 'are proposed', the responsible body 'must as soon as practicable take such steps as are practicable to ensure that' the cared-for person and any appropriate person understands the nature of the arrangements, the effect of authorisation, and core rights including reviews and challenge.³³³ After authorisation, copies of the authorisation record must be given to the cared-for person and any IMCA or appropriate person representing them.³³⁴

In some respects, the LPS adopt a more sophisticated approach to rights to information than the DoLS, with potential for higher quality *accessible* general information than exists presently. However, unlike the DoLS, a person who is consulted during the LPS process is not entitled to a copy of the authorisation record unless they are the 'appropriate person'. This means friends and family may struggle to access the authorisation record if not considered 'appropriate' to represent the person.

I. Court or Tribunal

Under the DoLS, an 'appeal' against detention is made through an application to the Court of Protection to review a DoLS authorisation under s21A MCA. As outlined above, there are significant concerns that this process is not being initiated when it should be – with the appeal rate currently standing at around 1 per cent. The government anticipates the rate of appeal will fall to 0.5 per cent of authorisations under the LPS, on the questionable basis that AMCPs will act as mediators in disputes.³³⁵

This fractional difference in estimated rates of appeal may seem trifling but holds the key to understanding the fundamental weakness in the scheme: the cost of challenges in the Court of Protection. In 2015 the median cost to a supervisory body of a s21A appeal was around £10,000, but could exceed £100,000 in complex cases, whilst the median cost of a legal aid certificate for either P or the RPR was £7,288 and the mean was £14,665.³³⁶ The sheer scale of the LPS, coupled with the very high cost of appeals, meant that depressing the estimated rate of appeal a mere 0.5 per cent shaved over £35m off the estimated cost of the entire scheme,³³⁷ a substantial proportion of the claimed £200m savings. Increasing rates of appeal beyond the already concerningly low rates under the DoLS would have wiped out any savings for the entire LPS scheme.

³³¹ This is contained in Sched AA1 s13 in the version of the Bill dated 12 December 2018 (Bill 303).

³³² MCA Sched AA1 s14.

³³³ MCA Sched AA1 s15.

³³⁴ MCA Sched AA1 s16.

³³⁵ 'Impact Assessment: Mental Capacity (Amendment) Bill' (2018) (n 123), at [12.32].

³³⁶ L Series, P Fennell and J Dougherty, n25.

³³⁷ The estimated costs for 0.5 per cent of LPS authorisations resulting in an appeal was £12.77m in legal aid costs, costs of £18.25 to responsible bodies and costs of £4.56m to the Official Solicitor. 'Impact Assessment: Mental Capacity (Amendment) Bill' (2018), n 123, at [12.32] – [12.37].

The complex reasons for the high costs of Court of Protection litigation are beyond the scope of this paper but appear to have exerted a chilling effect on improving rights of challenge under the LPS. The solution, of course, is to reform the Court of Protection itself – addressing other associated concerns including delay, accessibility and participation in the proceedings.³³⁸ Throughout the history of the MCA and the DoLS, the idea of a tribunal to adjudicate disputes has been debated, and well supported at consultation by those favouring an informal, accessible and efficient form of dispute resolution.³³⁹

The Law Commission initially favoured a tribunal under the LPS,³⁴⁰ as did the majority of consultees, but this was opposed by Court of Protection stakeholders.³⁴¹ However, in their final report the Commission noted difficulties separating out LPS appeals from wider health and welfare matters which remained within the jurisdiction of the Court of Protection. This concern tacitly acknowledges the difficulties outlined above in separating out the 'arrangements' authorised under the LPS from the underlying care and treatment decisions made under the MCA. Devolution of the mental health tribunals in Wales also presented difficulties. The Commission called for a further review of the appropriate judicial body for LPS appeals.³⁴² The JCHR also recommended the government consider a tribunal or reform of the Court of Protection.³⁴³ However, the promised review is still awaited³⁴⁴ and so the forum for appeal under the LPS remains the unreformed Court of Protection under a new provision – s21ZA.

J. Reviewing the 'Arrangements'

The troubled distinction between underlying care and treatment decisions made under the MCA, and the 'arrangements' to enable these, surfaces again in relation to court reviews. Challenges to decisions made under the main provisions of the MCA are rare,³⁴⁵ in part because of restrictions on financial eligibility for legal aid. Following *Cheshire West*, a number of challenges were brought under s21A. Many related to ancillary matters such as a person's capacity to make decisions around sex or contact,³⁴⁶ and even serious medical treatment decisions such as the withdrawal of artificial nutrition and hydration from people with severe brain injuries.³⁴⁷ In *Director of Legal Aid Casework & Ors v Briggs*³⁴⁸ the Court of Appeal ruled that this was an illegitimate use of legal aid for s21A challenges, but held that matters like 'contact' still fell within the ambit of DoLS appeals. It seems quite possible

³³⁸ L Series, P Fennell and J Doughty, n 25.

³³⁹ E.g. Law Commission, *Mentally Incapacitated Adults* (Law Com No 231, 1995) at [10.3] – [10.8]; 'Protecting the Vulnerable: the "Bournewood" Consultation: Summary of Responses', n 31, at [31]-[36].

³⁴⁰ Law Com CP 222, n 53, Provisional proposals 11-1 – 11-4.

³⁴¹ 'Mental Capacity and Deprivation of Liberty - Consultation Analysis', n 186, Chapter 10.

³⁴² Law Com No 372 (n 71) Recommendation 34.

³⁴³ Joint Committee on Human Rights, *The Right to Freedom and Safety*, n65, at [64-5]

³⁴⁴ Department of Health and Social Care, 'The Government's Response to The Joint Committee on Human Rights 7th and 12th Reports (2019)', at [1.17], at: <https://www.parliament.uk/documents/joint-committees/human-rights/Govt-response-7-12-JCHR.pdf>.

³⁴⁵ L. Series, P. Fennell and J. Doughty, n 25; L. Series, P. Fennell and J. Doughty, 'The Participation of P in Welfare Cases in the Court of Protection' (Report for the Nuffield Foundation, Cardiff University, 2017) at: <http://orca.cf.ac.uk/98448/>.

³⁴⁶ L. Series, P. Fennell and J. Doughty, n 25.

³⁴⁷ J. Cowley, 'How the DoLS can give voice to people with minimal consciousness' (Community Care 27 January 2017) at: <http://www.communitycare.co.uk/2017/01/27/dols-can-give-voice-people-minimal-consciousness/>.

³⁴⁸ *Director of Legal Aid Casework & Ors v Briggs* [2017] EWCA Civ 1169; [2018] Fam. 63.

the Legal Aid Agency may make further attempts to restrict the nature of challenges that can be brought under s21ZA, relying upon the 'bright line' distinction between care and treatment decisions and the arrangements emphasised in connection with the LPS.

K. The Definition of Deprivation of Liberty

Although it was hoped that *Cheshire West* would definitively answer the question 'what is a deprivation of liberty?', there continued to be pressure for a statutory definition. Some respondents to the Law Commission's consultation hoped to reverse *Cheshire West*.³⁴⁹ The Law Commission, whilst sympathetic, concluded this was 'misguided' since it could create gaps between the LPS scheme and the interpretation of article 5 by the courts under the Human Rights Act 1998 (HRA).³⁵⁰

The JCHR was also troubled by the consequences of *Cheshire West*, and particularly concerned by the application of the 'acid test' in domestic settings. Echoing its earlier call for a statutory definition the JCHR considered two possibilities.³⁵¹ They concluded that a 'causative' approach based *R (Ferreira) v HM Senior Coroner for Inner South London*,³⁵² which holds that if the person's 'underlying condition was the cause' of their not being free to leave this does not engage article 5, could give rise to difficulties in interpretation and be viewed as discriminatory.³⁵³ The second approach, which found more favour, tackled an element of deprivation of liberty not considered by the Supreme Court in *Cheshire West*: whether a person has given a 'valid consent' to their confinement.³⁵⁴ Basing its recommendation on a submission from Alex Ruck Keene³⁵⁵ (who worked at the Law Commission on the LPS proposals) the Committee proposed a broader approach to 'valid consent' than the MCA's binary test of mental capacity.³⁵⁶ This, they suggested, was supported by the CRPD Committee's rejection of the binaries of 'mental incapacity'.³⁵⁷

A draft amendment specified that for the purposes of determining whether a person is deprived of their liberty under the LPS, the cared-for person should be considered to have given a 'valid consent' if they are 'capable of expressing their wishes and feelings (verbally or otherwise)', they had expressed 'their persistent contentment' with the arrangements, there was 'no coercion involved' in their implementation, and this was confirmed in writing by two professionals (one independent of the person's care).³⁵⁸ This CRPD-influenced proposal could have resolved some of the more jarring outcomes of *Cheshire West*, such

³⁴⁹ Law Com No 372, n 71, [5.36-7]

³⁵⁰ Ibid, [5.37].

³⁵¹ JCHR, *The Right to Freedom and Safety: Reform of the Deprivation of Liberty Safeguards*, n 65, Chapter 5.

³⁵² [2017] EWCA Civ 31; [2018] Q.B. 487; [2017] Inquest L.R. 118; [2017] M.H.L.R. 258.

³⁵³ Twelfth Report of Session 2017–19, 'Legislative Scrutiny: Mental Capacity (Amendment) Bill' (HC 1662 HL 208) at [24].

³⁵⁴ See *Storck v Germany*, n 310, at [74].

³⁵⁵ Written evidence from A. Ruck Keene (DOL0120) submitted to the JCHR's inquiry into 'The Right to Freedom and Safety' (n 65), at: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/human-rights-committee/the-right-to-freedom-and-safety-reform-of-the-deprivation-of-liberty-safeguards/written/80869.html>.

³⁵⁶ JCHR, n 65, at [43-4]

³⁵⁷ Committee on the Rights of Persons with Disabilities, *General comment No. 1 (2014) Article 12: Equal recognition before the law* (UN Doc CRPD/C/GC/1).

³⁵⁸ JCHR, n 353, 12-13.

as the conclusion that Steven Neary is deprived of his liberty in his own home, where he actively wishes to live, whilst still providing procedural safeguards.³⁵⁹ It was tabled by Lord Woolf,³⁶⁰ but rejected by the government on the basis that it conflicted with the position under the ECHR and would create a 'gap' in protection under the LPS scheme.³⁶¹

Initially the Government accepted the Law Commission's recommendation against a statutory definition of deprivation of liberty.³⁶² However, under pressure from stakeholders and the JCHR the government published its own statutory definition of deprivation of liberty only days before the Public Bill Committee in the House of Commons.³⁶³ That definition was resoundingly criticised by stakeholders.³⁶⁴ It would have excluded arrangements where a person's ability to come and go from the place of their confinement was only temporary and potentially subject to permission seeking requirements, in direct contradiction of ECHR case law.³⁶⁵ It created latitude to escape scrutiny under the LPS by asserting that 'if the person expressed a wish to leave the person would be enabled to do so' – an approach that was rejected by the courts in both *Bournewood* and *Cheshire West*.³⁶⁶ The government's statutory definition was rejected in the Lords and replaced with an alternative definition,³⁶⁷ which was subsequently rejected by the House of Commons.

The final position agreed by both houses is that the 2019 amendments do not define deprivation of liberty, however guidance on those arrangements falling within scope of the LPS must be given in the Code of Practice, which must be reviewed within three years of coming into force and every five years thereafter.³⁶⁸ This approach, whilst no doubt unsatisfactory to those hoping to reverse *Cheshire West*, at least has the merit of not creating a constitutional nightmare for any court faced with conflicting interpretations of deprivation of liberty from the ECtHR, the Supreme Court and Parliament. The Code has more space for detail and nuance, and can be revised as case law develops. Nor does this approach preclude a legal challenge on what constitutes a 'valid consent' under the LPS, in the manner advocated for by the JCHR.

³⁵⁹ L Series (n 73).

³⁶⁰ Hansard, HL Series 5 col 250, n 197.

³⁶¹ Ibid, col 252 (The Lord O'Shaughnessy).

³⁶² 'Final Government Response to the Law Commission's review of Deprivation of Liberty Safeguards and Mental Capacity', n87, Response to recommendation 2. However, see also 'Annex A: Law Commission recommendations and Government Responses', n 87.

³⁶³ This can be found in the amendment paper dated 13 February 2019 on the Bill's parliamentary webpage: <https://services.parliament.uk/Bills/2017-19/mentalcapacityamendment/documents.html>.

³⁶⁴ See submissions to the Public Bill Committee from, e.g. Court of Protection Practitioners' Association, Doughty Street Chambers, Independent Age, Irwin Mitchell, Jess Flanagan (solicitor), Lucy Bright BIA), Lucy Series, Royal College of Psychiatrists, Roger Laidlaw (DoLS lead). The Royal College of Nursing, however, did support the government's proposed definition. At: <https://services.parliament.uk/Bills/2017-19/mentalcapacityamendment/committees/houseofcommonspublicbillcommitteeonthementalcapacityamendmentbillhl201719.html>.

³⁶⁵ *Stanev v Bulgaria*, n15.

³⁶⁶ *HL v UK*, n27, at [46], [86], [91]; *Surrey County Council v MEG & MIG v Anor* [2010] EWHC 785 (Fam), at [233]; M.H.L.R. 108 [2011].

³⁶⁷ Available in the amendments dated 3 April 2019 on the Bill's website (HL Bill 171).

³⁶⁸ MCA s42, as amended by MCAA s4.

VI. CONCLUSION

The Government's aim in the 2019 amendments to the MCA was to 'reform a broken and bureaucratic DoLS system',³⁶⁹ provide 'proportionate' safeguards, increase flexibility, reduce complexity, and save £200m. The final Act is a different beast from the heavily criticised Bill introduced in July 2018, but it also differs from the Law Commission's proposals, which rested on improvements to the operation of the MCA, and much wider access to independent advocacy. Have the 2019 amendments achieved the government's aims, or should we agree with Baroness Murphy's assessment that Parliament has failed in its task?³⁷⁰

For those hoping to reverse *Cheshire West*, or concerned that the LPS will now pursue people 'in their own homes'³⁷¹, the 2019 amendments will disappoint. The LPS will provide safeguards that are currently entirely absent for people in settings such as supported living, and potentially improve access to justice through expanding the number of people eligible for legal aid via s21ZA challenges. Yet people in care homes and hospitals will lose layers of protection that the DoLS deliver in theory (although often not in reality). The scheme is highly vulnerable to human rights challenges, particularly around its provisions for representation, renewals and appeals, unless creatively patched up by the Code and the courts, as the DoLS themselves were.

The LPS attempt to secure article 5 compliance on an unprecedented scale by giving responsible bodies considerable discretion in how they deliver the safeguards. This flexibility introduces both complexity and risk. Some responsible bodies will no doubt use the LPS as they have the DoLS – to scrutinise and address restrictive practices and resolve disputes. Others will be less vigilant, and the next generation of *Neary* type litigation will consider how responsible bodies exercise their considerable discretion over assessments, determinations, renewals, reviews and fundamental safeguards including representation, advocacy and appeals. The risk remains that some people who are deprived of their liberty will not receive any safeguards at all. Even following *Cheshire West* there is considerable variability in the age standardised rates of DoLS applications across supervisory bodies, raising the possibility that some supervisory bodies are more proactive than others in securing article 5 safeguards.³⁷²

The LPS foreground the wishes and feelings of the person in a way that the DoLS often failed to do. 'Objections' is the weight bearing concept for the crucial safeguard of AMCP review. Courts and practitioners will have to grapple with the complexities of working out what a person wants, and what it means to 'object', when one's methods of communication are (at least to others) unclear or disputed, or even suppressed by one's circumstances. This is not the 'will and preferences' paradigm exhorted in connection with the CRPD, but it is a step in that direction.

At the heart of the DoLS and the LPS lurks an anxiety, about the kinds of power that are exercised within caregiving relationships, particularly where the care recipient is unlikely to

³⁶⁹ Hansard, HL Series 5 col 612, n 1 (The Baroness Blackwood of North Oxford).

³⁷⁰ Ibid, col 616.

³⁷¹ Ibid.

³⁷² NHS Digital (2019); (n 11).

be able to alert others to problems. It is doubtful that article 5 is the best mechanism for addressing this in some of the circumstances where the LPS will now apply.³⁷³ But there were few other available vehicles for securing independent scrutiny and challenge under the MCA, and no sign of a government seeking to remedy this. *Bournewood* and *Cheshire West* held a gun to the government's head,³⁷⁴ and the LPS was the reply.

We are left with our unanswered question: what are these safeguards *for*? Are they, as Baroness Murphy suggests, addressing 'a problem we did not know we had', instigated by the judiciary³⁷⁵? The circular answer of article 5 compliance does not help us. We might ask what article 5 is protecting Steven Neary from today, living happily in his own home? Telling thousands of families that they are detaining their relatives feels like political dynamite at a time when human rights are increasingly vulnerable.³⁷⁶ Yet there are very real concerns about coercion and restrictive practices in a broad range of care settings, with limited alternative scrutiny, and few realistic avenues for disabled people and families to challenge decisions made under the MCA. Whether the LPS will assist in addressing the substantive issues, or merely draw a veil of legitimacy over the 'arrangements', remains to be seen.

POSTSCRIPT

This article was written in 2019, when we inhabited another world, before the coronavirus pandemic of 2020 and the UK lockdown. Although the UK government has introduced 'easements' to the MHA in response to the coronavirus Act, it has not done so for the MCA or the DoLS. Expectations that people in care homes will be 'isolated' in their rooms, and the imposition of 'lockdown' measures raise specific issues for the MCA and the DoLS that have not as yet been addressed.³⁷⁷ The likelihood is that many more people are now effectively deprived of their liberty in care homes and other care settings – often unlawfully – in response to the pandemic. It is also likely that work on the new Codes of Practice and regulations, and implementation of the LPS, will be significantly delayed by this crisis.

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³⁷³ L Series (n 73).

³⁷⁴ An observation of solicitor Richard Jones, a seasoned critic of the DoLS, in response to: A. Ruck Keene, '*Cheshire West: The Supreme Court's Right Hook*' (Mental Capacity Law and Policy 19 March 2014) <http://www.mentalcapacitylawandpolicy.org.uk/cheshire-west-the-supreme-courts-right-hook/#comment-13>

³⁷⁵ Hansard, HL Series 5 col 1097 n 89.

³⁷⁶ E.g. J. Sumption, 'Lecture 3: Human rights and wrongs' (The Reith Lectures, BBC Radio 4, 4 June 2019).

³⁷⁷ Alex Ruck Keene, 'Capacity in the time of Coronavirus', (2020) *International Journal of Law and Psychiatry*, DOI: 101560.